BY ORDER OF THE
SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 41-106

1 JULY 2011

Health Services

MEDICAL READINESS PROGRAM MANAGEMENT

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available on the e-Publishing website at **www.e-publishing.af.mil** for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFMSA/SGX

Certified by: AF/SG3 (Col James Collier)

Pages: 167

Supersedes: AFI 41-106, 14 April 2008

This Instruction implements Air Force Policy Directive (AFPD) 41-1, *Health Care Programs and Resources* and DOD Instruction (DODI) 1322.24, *Medical Readiness Training*. It sets procedures for medical readiness planning, training, exercising and reporting in support of the full spectrum of medical operations, including expeditionary, humanitarian assistance, disaster response, global health engagement and stability operations. This Instruction applies to Active Component (AC) and Air Reserve Component (ARC) units and may be supplemented at any level, but all direct Supplements must be routed to the Office of Primary Responsibility (OPR) of this publication for coordination prior to certification and approval. **Note**: Guidance in this Instruction applicable to MAJCOMs also applies to the National Guard Bureau (NGB).

Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records,* and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at **https://www.my.afrims/afrims/afrims/rims.cfm**.

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This Instruction requires collecting and maintaining information protected by the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. System of Records notice F036 AF PC C, Military Personnel Records System, applies.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include: Removal of AE operational guidance, inclusion of Consultant Balanced Deployments (CBD) roles and responsibilities, new C-NAF and AFIA roles and responsibilities with regard to deliberate and crisis planning and deployed MTF assessments, enhanced C-STARS program guidance and consultant/CFM roles and responsibilities, to include waivers, exemptions, and non-standard attendees, inclusion of Sustainment of Trauma and Resuscitation Skills Program (STARS-P), elimination of the Medical Readiness Training and Exercise Plan (MRTEP) requirement, enhanced medical readiness guidance for Limited Scope (LS) and Limited Scope with Inter-service Support (LSISS) MTFs, enhanced guidance for MC-CBRN program oversight, management, training, exercising, reporting, funding and allowance standard inventory requirements, inclusion of medical-specific HAZMAT training guidance recently removed from AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*, established Air Force Reserve Command (AFRC) MC-CBRN program guidance, established ANG CBRNE Enhanced Response Force Packages (CERFP) and Homeland Response Force (HRF) program guidance, and established the deployed facility assessment process and checklists.

Chapter 1

AIR FORCE MEDICAL SERVICE READINESS

1.1. Mission Overview. The Air Force Medical Service (AFMS) provides seamless health service support to AF and combatant commanders and assists in sustaining the performance, health and fitness of every Airman in-garrison and while deployed within the Continental United States (CONUS) or overseas (OCONUS) in support of global operations. This capability is summarized by the phrase "global medical readiness" which includes the full spectrum of medical operations (expeditionary deployment operations, humanitarian assistance, disaster response, and global health engagement to support building partnerships and stability operations). It also includes the necessary planning, training, and readiness support functions (reports, disaster management, and others) associated with these operations. Components of this global system are fully integrated, with forward-deployed medical support, and en route care to facilities providing comprehensive definitive medical specialty care. The foundational emphasis is on prevention of illness and injury. When illness or injury does occur, the AFMS provides a rapidly responding modular medical capability which can be tailored to meet specific requirements. If more definitive care is required, the AFMS supports an effective "evacuate and replace" policy through aeromedical evacuation (AE) of joint and combined forces. With this focus on preventive medicine, superior health care, and aeromedical evacuation, the AFMS promotes and advocates the optimization of human performance sustainment and enhancement, including the optimal integration of human capabilities with operational systems. To achieve the mission, the AFMS developed processes to support operational strategies, emergency management, medical readiness training, manpower and equipment force packaging, medical readiness resourcing, aeromedical evacuation and global medical operations plans and reporting. The following sections will introduce these areas:

1.2. Operational Strategies. The AFMS employs multiple planning strategies to ensure capabilities are organized, trained, equipped, and available to meet contingency requirements.

1.2.1. **Modular Capabilities.** The AFMS provides a light, lean, modularized medical capability that can be deployed rapidly to support operations overseas and at home.

1.2.1.1. Most initial medical support begins with either the Global Reach Laydown (GRL) team or the Squadron Medical Element (SME). The GRL UTC FFGRL consists of four personnel and is assigned to the Contingency Response Group (CRG) to provide medical support during rapid opening of contingency airfields. The purpose of the CRG is to bring significant order, foresight, speed, and safety during the critical opening days of a contingency. The SME is a small team consisting of a flight surgeon and two medical technicians attached to an AF flying squadron. This team deploys with the squadron and provides care and initial preventive medicine surveillance. As support to the expeditionary squadron grows, the SME can be augmented with additional independent duty medical technicians (IDMTs) and a preventive aerospace medicine (PAM) team. The PAM team provides aerospace medicine support during the opening of a contingency airbase, including performing the GRL role described in this Instruction if that UTC is not tasked. If the beddown site becomes a more permanent operating site or the population at risk (PAR) increases, the AFMS can deploy the Expeditionary Medical

Support (EMEDS) system. The scalable nature of EMEDS allows the AF to deploy capabilities from small teams that can provide highly skilled medical care for a limited number of casualties, to a medical system as large as an Air Force Theater Hospital (AFTH) that can provide specialized medical care to a PAR of several thousand.

1.2.1.2. For casualties requiring more definitive care than that provided by the EMEDS, the Global Patient Movement System can provide rapid movement of patients to the appropriate level of care. As a component of the USAF Mobility Air Forces (MAF) system, AE crews provide en-route medical care to stabilized patients during transport on MAF aircraft. Critical Care Air Transport Teams (CCATTs) are used to augment AE crews to provide advanced specialty medical capability to evacuate critically ill, injured, or burned patients requiring continuous stabilization and advanced care during transport.

1.2.1.3. These modular capabilities are organized by force modules to complement increases in combat capability. As a beddown grows, predetermined support assets, including medical assets, are deployed to that beddown. These predetermined modules provide an organized expansion capability, offer predictability to the supporting units, and simplify the planning process.

1.2.1.4. In addition to missions associated with aircraft beddown locations, AFMS forces may deploy in support of stability operations, engage in military missions, tasks, and activities to reestablish a safe and secure environment and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief.

1.2.2. **Capabilities-based Planning**. The AF has shifted from a programs/platforms mentality to capabilities-based planning. Commanders and their planners identify requirements for specific capabilities not for units, and those capabilities are then associated with trained and available unit type codes (UTCs). In order to quantify capabilities, the OSD has directed that all Services observe, assess, and report their units' ability to perform through mission essential tasks (METs) measured against a specific standard.

1.2.3. **Constant Deployer Model (CDM).** The AFMS supports the Air and Space Expeditionary Force (AEF) strategy and postures its deployable capabilities evenly across the AEF Tempo Band construct. These deployable forces are assigned to large medical treatment facilities using a CDM. The model maximizes laydown of key teams at facilities most able to provide the complex clinical caseload required for clinical currency while simultaneously providing sufficient copies of a UTC to support each AEF pair. By concentrating deployment capability at large facilities, individuals and teams are able to leverage their home-station responsibilities to maintain readiness currency in individual tasks, and to a large degree, team METs. A disadvantage of this laydown strategy is that teams may not be collocated as force packages and may need to converge at an external training event for force package training. For example, all UTCs required for an AF Theater Hospital may not be located at one place, and may have to converge for training. A focus on METs will optimize the training of individuals, teams, and leaders in the context of this force laydown strategy, ensuring all are trained on the same tasks prior to deployment.

1.2.4. **AEF Tempo Band Construct.** The AEF Tempo Band construct, also referred to as "Global AEF," was designed to accommodate high operations tempo and enduring operations, while continuing to provide AF personnel a high level of deployment predictability and force stability.

1.2.4.1. The AEF Tempo Band Construct places Combat Service Support (CSS) forces in one of several bands based on force level and warfighter requirements. As the situation changes, capabilities are moved up or down bands by adjusting dwell. The AF baseline for the active component (AC) is Tempo Band B, which is at a 1:4 deploy-to-dwell ratio (deploy for 6-months, and in dwell for 2-years). As requirements increase, AC forces can be moved to Tempo Band C (1:3), Tempo Band D (1:2), or Tempo Band E (1:1). As requirements drop, the goal is to return back to a higher band (i.e. Band B) as soon as possible.

1.2.4.2. ARC forces have unique bands that follow the same methodology. The two ARC mobilization Tempo Bands consist of nine 6-month blocks (Band "M") and eight 6-month blocks (Band "N") respectively. The blocks in Bands "M" and "N" are predicated on a 6-month employment period within a 9-month mobilization period. **Note:** At execution, mobilization periods may be other than 9 months.

1.2.4.3. Forces in an organize, train, or equip capacity (typically above the Wing HQ staff and/or training units), are designated as Institutional Forces (IF). They are available to meet unique warfighter requirements but are not a part of the traditional Tempo Band construct. Instead, they are designated as Band X at a 1:4 dwell. Dwell will not be adjusted for IF based on changes in requirements.

1.2.4.4. Due to the nature of the AE system, all active duty AE unit-assigned forces are considered enablers. As such they are not included in the AEF Tempo Band construct.

1.2.4.5. Additional guidance and information may be found in AFI 10-401, *Air Force Operations Planning and Execution,* and the AFMS Posturing and Sequencing Guide.

1.2.5. **Consultant Balanced Deployments (CBD).** The Consultant Balanced Deployments (CBD) concept ensures AEF deployment requirements are met using the most qualified individuals available at any one time from across the AFMS by balancing deployments for their specialty, primarily those considered low supply, high demand (LS/HD) Air Force Specialty Codes. Additionally, this concept limits interruptions to home station health care and maximizes individual career development and growth.

1.2.5.1. Consultants and Career Field Managers (CFMs) for LS/HD specialties associated with deployable capabilities review personnel UTC assignments for their functional areas. Based on that review, when assets are limited, consultants and CFMs may recommend to unit commanders personnel realignments within the constraints of the AEF construct. In order to provide team integrity, consultants and CFMs must maximize use of personnel from the same facility or organizational command when recommending UTC fills. Consultants and CFMs may recommend to the AEF Operations Center individuals from other MAJCOMs to complete the UTC for a specific AEF rotation at execution, when required. Unit commanders have the ultimate authority for posturing their personnel and should consider consultant and CFM recommendations when making these decisions.

1.2.5.2. The AFMS CBD liaison at the AF Medical Operations Agency (AFMOA) coordinates consultant or CFM recommended changes, sourcing solutions, or other personnel deployment-related activities with the MAJCOM/SGXs, AFMS Functional Area Manager (FAM), and the AEF Operations Center.

1.2.5.3. Consultants and CFMs will use prioritized lists of personnel in their AFSCs to recommend fills for short notice requirements or substitutions when requested.

1.2.5.4. Additional responsibilities associated with CBD are addressed in paragraph 2.1.10 of this Instruction.

1.2.6. **Stability Operations.** The term "stability operations" refers to various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, and provide essential government services, emergency infrastructure reconstruction, and humanitarian relief. The Air Force must be prepared to work with other Services to conduct stability operations throughout all phases of conflict in both combat and non-combat environments. Stability operations may be small or large scale, lasting for the short or long-term.

1.2.6.1. Integrated military and civilian operations are essential to successful stability operations; consequently, the Air Force will collaborate with other Services and US governmental agencies, foreign governments, international government and nongovernmental organizations, and private sector firms as directed to plan, prepare for and conduct stability operations. The AFMS has a critical role in supporting stability operations by providing essential medical services and providing humanitarian assistance.

1.2.6.2. AF medical personnel and capabilities must be prepared to meet military and civilian health requirements in medical stability operations. To meet this requirement, training will be provided to prepare personnel for stability operations in accordance with DODI 3000.05, *Stability Operations* and DODI 6000.16, *Military Health Support to Stability Operations*.

1.2.7. **Joint Interoperability.** The AF fights jointly. In recent years, OSD has reinforced commitment to joint interoperability and joint training in most strategic planning and training documents. This commitment is seen in using METs for training and expanding training opportunities through the use of joint field exercises as training venues for AFMS teams, when appropriate. Teams that are likely to deploy with medical teams from a different Service, or in direct support of a joint operation such as casualty staging and CCATTs, are prime candidates for a joint exercise operation.

1.3. Medical Emergency Management. AF Fixed medical facilities worldwide are required to plan for conducting their home station and expeditionary missions simultaneously. Home station missions include facility expansion, which can increase the bed capacity of many of the medical treatment facilities (MTFs) to receive and care for large numbers of casualties; patient decontamination; and medical response/support to contingencies confined to the installation or involving Federal, State, Local, or Tribal agencies, or Host Nation governments, including Medical Counter-Chemical, Biological, Radiological, Nuclear (MC-CBRN) events. The AFMS also participates in the National Disaster Medical System (NDMS) with Federal Coordinating Centers (FCCs) capable of receiving, triaging, and distributing civilian patients to NDMS hospitals and with Primary Receiving Centers and Secondary Centers capable of receiving, treating and holding military patients resulting from a military or homeland contingency. Designated AF MTFs serve as FCCs and Secondary Coordinating Centers (SCCs) within the NDMS, providing support and leadership to the local hospitals contributing to the NDMS bed capability. Air National Guard medical personnel may be tasked to serve at the Joint Force

Headquarters (JFHQ) Joint Operations Center as planners and liaison officers to provide state level Defense Support to Civil Authorities (DSCA). To maintain a capability to respond to all contingencies, the AFMS relies on highly-trained medical warriors and state-of-the-art, light, ruggedized medical equipment. Comprehensive planning and realistic exercises ensure personnel are prepared to support expeditionary and humanitarian assistance and disaster relief (HA/DR) operations. Overarching governance for AF emergency management is contained in AFPD 10-25, *Emergency Management.* Specific details on the AFMS emergency management mission are provided throughout this Instruction. Additional information on NDMS can be found on the AF Medical Readiness CoP in the NDMS folder.

1.4. Medical Readiness Training. AFMS personnel require highly specialized initial, sustainment, and theater-specific training to respond to varied missions and environments. A continual assessment process ensures this training remains relevant and effective.

1.4.1. **Current Training System.** Training is provided for individuals, teams (collective training), and leaders, and prepares personnel to integrate themselves into joint medical platforms and situations. The training system includes AFSC-awarding training courses, clinical currency platforms, courses for deployment platforms, local courses and briefings, and exercises.

1.4.2. **Fully Qualified Mindset.** Personnel should not be assigned to a readiness tasking or standard UTC until they hold a fully qualified AFSC (4XX3 for officers or 4XX51 enlisted). However, personnel holding AFSCs 4XX1 for officers and 4XX31 for enlisted may be substituted on UTCs in accordance with AFI 10-403, *Deployment Planning and Execution*, as long as sufficient oversight and skill capability is present on the UTCs. The unit commander must review UTC assignments to ensure mission capability.

1.5. Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies (MRA). To maintain the viability and effectiveness of its deployable medical capabilities, the AFMS has assigned MEFPAK responsibilities to MAJCOM/SGXs. Air Combat Command is the MRA for medical ground-based unit type codes (UTCs) and Medical Counter-Chemical, Biological, Radiological, Nuclear (MC-CBRN) Allowance Standards. Air Mobility Command is the MRA for AE, patient staging, and aeromedical enroute care support personnel and equipment UTCs, and patient movement items (PMI). Air Force Special Operations Command is the MRA for special operations medical UTCs. PACAF and USAFE may maintain responsibility for theater-unique capabilities with AF/SG3X approval. Pilot units work closely with the MRAs to construct UTCs, associated mission capability statements (MISCAPs), and manpower details.

1.5.1. **Mission Essential Tasks (METs).** MRAs will develop UTC METs based on force module packaging or for stand-alone UTCs, and will incorporate them into the appropriate MRA Playbook. See paragraph 2.1.12.2 for additional information on the MRA Playbook.

1.5.2. **MRA Resourcing.** MRAs request funding for the modernization and sustainment of their UTCs and MC-CBRN allowance standards (AS) through both Line of the Air Force (LAF) and medical programming channels.

1.6. Medical Readiness Resourcing. To maintain a robust medical readiness capability, the AFMS manages the funding for training, exercises, personnel and equipment through an internal planning, programming, and budgeting system.

1.6.1. **Medical Readiness Panel**. The Medical Readiness (MR) Panel ensures resources are provided across the AFMS to create and maintain global response initiatives. Medical readiness resources are provided by Defense Health Programs (DHP) funding for operations and maintenance (O&M) and PMI, and LAF funding for War Reserve Materiel (WRM) and MC-CBRN assets.

1.6.2. **Business Planning.** Medical treatment facility commanders are expected to execute a business plan that maximizes the use of assigned personnel and available resources. This strategy allows a commander to plan and execute effective training at a predictable cost in terms of both resources and medical treatment facility production in three ways; readiness case analysis, currency case analysis, and business case analysis. Readiness is a critical element of business planning and should include training requirements, exercise opportunities, and deployment and contingency response obligations.

1.6.3. **Medical Counter-CBRN (MC-CBRN) Resources.** The AFMS utilizes LAF funds to provide critical capabilities to the Air Force in countering CBRN threats and mitigating the impact of CBRN attacks on personnel and the mission. AF MTFs and non-collocated ANG medical units will maintain the capabilities described in this Instruction organically within the medical organization, by establishing written mutual aid agreements (MAAs) with local medical and emergency response organizations, other MTFs in the local area, or through a combination of these methods. For full-time AFRC bases, this capability is maintained by the Bioenvironmental Engineering/Public Health office. MC-CBRN resources (also referred to as Home Station Medical Response, HSMR, in unrevised documents) are programmed at the AF/SG and NGB/SG levels, consolidating input from Major Commands (MAJCOMs) and direct reporting units (DRUs), and advocating for MC-CBRN requirements through the AF and ANG Installation Support Panels.

1.6.4. **Unit Medical Operations Resourcing.** The unit Medical Readiness Committee (MRC), or Executive Management Committee (EMC) for ARC units, identifies unit readiness training and resource requirements and provides a consolidated document to their respective MAJCOM. For a full discussion of medical resource processes and procedures see AFI 41-120, *Medical Resource Operations.*

1.7. Aeromedical Evacuation (AE). The AFMS partners with the Operations (A3) community to provide AE capability for homestation and global operations. The A3 staff provides comprehensive operational AE guidance, while the SG staff is responsible for clinical guidance for AE medical crews and medical/training guidance for ground AE UTCs, including WRM medical equipment allowance standards and operational CCATT/AE kit support program. Training, plans, and reporting requirements listed in this Instruction for fixed medical facilities (medical units) do not apply to AE units.

1.8. Global Medical Operations Plans and Reporting. Realistic, comprehensive plans that describe responsibilities and procedures to perform the unit's mission are critical in building and maintaining highly effective medical response. Reporting systems, such as Status of Resources and Training System (SORTS), Defense Readiness Reporting System (DRRS) Enhanced Status of Resources and Training System (ESORTS), AEF Reporting Tool (ART), and other reports, provide planners at Combatant Commands, MAJCOMs, and senior leaders valuable data with which to make planning and resourcing decisions relevant to myriad AF taskings. Unit planning for global medical operations is discussed in Chapter 5, and medical readiness reports are discussed in Chapter 9 of this Instruction.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. Purpose. This chapter describes roles and responsibilities for Air Force Medical Readiness (MR) programs, including those at the Air Force, MAJCOM, installation and unit levels. It also describes responsibilities of supported and supporting organizations such as the Air Force Inspection Agency, Air Force Expeditionary Medical Skills Institute, and others.

2.1.1. **Air Force Surgeon General (AF/SG).** This individual will:

2.1.1.1. Develop medical policy for SECAF approval and issue guidance and procedures to implement the policy.

2.1.1.2. Advocate for, obtain, and allocate resources for medical activities.

2.1.1.3. Continually evaluate AFMS ability to support AF and DOD missions.

2.1.1.4. Integrate AFMS capabilities with other Air Force and Joint capabilities at the development and execution stages.

2.1.1.5. Establish and disseminate training and assessment guidance.

2.1.1.6. Establish the MR Panel by charter to plan, program, and budget for readiness resources.

2.1.2. **Assistant Surgeon General, Medical Force Development (AF/SG1).** This individual will:

2.1.2.1. Establish medical force development guidance.

2.1.2.2. Recruit and retain personnel required for all medical missions.

2.1.2.3. Develop and implement career paths to ensure leadership and professional development.

2.1.2.4. Ensure medical personnel receive initial and recurrent training necessary to meet operational requirements.

2.1.3. **Assistant Surgeon General, Health Care Operations (AF/SG3).** This individual will:

2.1.3.1. Develop medical readiness doctrine, guidance, and programming. Publish and maintain associated directives.

2.1.3.2. Advocate for, obtain, and allocate resources for medical readiness activities, including training.

2.1.3.3. Recommend medical readiness strategies to the AF/SG.

2.1.3.4. Ensure Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS ULTRA) is maintained and funded, and continues to be enhanced as AFMS mission requirements evolve.

2.1.3.5. Develop a functional AEF medical UTC deployment strategy.

2.1.3.6. Publish the Medical Resource Letter (MRL), identifying AFMS UTC and MC-CBRN assemblage apportionment.

2.1.3.7. Designate the Director, Medical Readiness AF/SG3X to:

2.1.3.7.1. Maintain the MRL and the medical UTC Availability (UTA). Host conferences as necessary to ensure expeditionary medical capabilities are balanced across the entire AEF cycle.

2.1.3.7.2. Coordinate with MAJCOM medical functional area managers (FAMs) to ensure maximum support of the AFMS UTC posturing strategy.

2.1.3.7.3. Coordinate with Air Reserve Component (ARC) FAMs to develop and fill UTCs to meet Air Force requirements.

2.1.3.7.4. Provide functional oversight and guidance to MAJCOM/SGXs on all aspects of medical readiness, to include guidance decisions, procedures, and publications; deployment and operational information and taskings; training development and opportunities; installation medical response guidance; and resource allocation.

2.1.3.7.5. Develop courses of action to balance AEF rotational requirements and beneficiary healthcare requirements.

2.1.3.7.6. Provide functional guidance and oversight of the Consultant Balanced Deployment (CBD) program.

2.1.3.7.7. Publish and maintain this Instruction in accordance with AFI 33-360, *Publications and Forms Management.* Publish and maintain the AFI 41-106 Toolbox on the AF Medical Readiness CoP.

2.1.3.7.7.1. Collect, track and evaluate change requests and publish changes to this Instruction as mission dictates.

2.1.3.7.7.2. Coordinate with the Air Force Inspection Agency (AFIA) on proposed medical readiness program element changes for Active Duty (AD), Air Force Reserve Command (AFRC) and Air National Guard (ANG) inspection criteria. Coordinate on proposed medical readiness program elements in the Health Services Inspection (HSI) Guide prior to publication.

2.1.3.7.8. Through the respective MAJCOMs, designate specific MTFs to operate as Laboratory Response Network (LRN) laboratories.

2.1.4. **Assistant Surgeon General, Strategic Medical Plans and Programs (AF/SG8).** This individual will:

2.1.4.1. Establish threshold manning levels required to support contingency requirements using planning tools including the Contingency Operational Readiness Requirement (CORR).

2.1.4.2. Program sufficient forces to meet changing operational requirements in the specialties needed.

2.1.5. **Air Force Medical Operations Agency (AFMOA).** This organization will:

2.1.5.1. Provide oversight to AFMS consultant and CFM functions.

2.1.5.2. Support the Readiness Skills Verification Program (RSVP) and Consultant Balanced Deployment (CBD) functions as described in paragraph 2.1.10 of this Instruction.

2.1.5.3. Provide funding, management direction and oversight in support of WRM Consolidated Storage and Deployment Center (CSDC) operations, PMI Centers, and PMI operational support and training platforms, in accordance with established Memorandums of Agreement (MOA).

2.1.6. **Air Force Medical Support Agency/Medical Readiness Directorate (AFMSA/SGX).** This directorate will:

2.1.6.1. Support the development of medical readiness doctrine, guidance, and programming. Provide daily oversight and accountability for medical readiness processes.

2.1.6.2. Provide functional guidance and assistance to MAJCOM/SGXs on all aspects of medical readiness, to include decisions, procedures, and publications; deployment and operational information and taskings; training development and opportunities; installation medical response guidance; and resource allocation, to include equipment funding.

2.1.6.3. Chair the MR Panel.

2.1.6.4. Establish the MRDSS Configuration Control Board (CCB) by charter to manage ongoing development of MRDSS. The MRDSS CCB approves or disapproves and prioritizes all proposed baseline hardware or software changes.

2.1.6.5. Establish the Readiness Training Oversight Committee (RTOC) by charter to review AFMS medical readiness training programs to ensure such programs are adequately designed to fulfill defined medical readiness training requirements. The RTOC will also plan, coordinate and oversee the AFMS exercise program. Units with unique or extensive exercise requirements beyond the scope of unit funding may submit their proposals through their MAJCOM/SGXs to the RTOC for consideration.

2.1.6.6. Establish the Medical Counter-CBRN Oversight Committee (MC-CBRN OC) by charter to review home station medical response issues. The MC-CBRN OC will provide input to plan, coordinate, and oversee the AFMS role in all hazards response. Because the program is managed centrally through the Installation Support Panel (a LAF panel), the MC-CBRN OC and the MR Panel serve an advisory role to the Installation Support Panel.

2.1.6.7. Provide recommendations to AFMOA/SGAL on procuring, storing, sustaining, reporting, and updating Medical Readiness program equipment and supplies.

2.1.6.8. Appoint a member of the AFMSA/SGX staff as the Program Element Manager (PEM) for the following DHP, Program Elements (PE): 87700 - Defense Medical Centers, Station Hospitals and Medical Centers – CONUS; 87714 - Other Health Activities; 87724 - Military Unique Requirements - Other Medical - Health Care; 87725 - Aeromedical Evacuation System - Health Care; 865XX – PMI; 87900 - Defense Medical

Centers, Station Hospitals and Medical Centers – OCONUS. The MR PEM is the primary advocate for medical readiness funding and supports the RTOC, MRDSS CCB, and the International Health Specialist (IHS) program.

2.1.6.9. Appoint a member of the AFMSA/SGX staff as the PEM for LAF PE 28036F, MC-CBRN program. The MC-CBRN PEM is the primary advocate to the Installation Support Panel on behalf of the AFMS for MC-CBRN program funding throughout all aspects of the AF Planning, Programming, Budgeting, and Execution System (PPBES) process.

2.1.6.10. Designate member(s) of the Homeland Medical Plans Division to manage the apportionment of MC-CBRN assemblages (886 AS) in the MRL. These individuals will also monitor MRDSS ULTRA data to identify personnel, training, and equipment/supply trends, shortfalls and gaps and proactively work resolutions through central procurements, policy, programming and modernization initiatives. Coordinate necessary changes or updates with HQ ACC/SGXH, as the Manpower and Equipment Force Packaging (MEFPAK) Responsible Agency (MRA) for MC-CBRN.

2.1.7. **Medical Inspection Directorate, Air Force Inspection Agency (AFIA/SG).** This agency will:

2.1.7.1. Assess medical unit capability to respond to the full spectrum of medical expeditionary and humanitarian assistance and disaster relief (HA/DR) missions.

2.1.7.2. Evaluate medical unit implementation of AF, AF/SG, and MAJCOM medical readiness policies and procedures.

2.1.7.3. Support deployed MTF assessments as described in paragraph 2.1.11.3 of this Instruction.

2.1.7.4. Provide guidance to MAJCOM/SGXs that conduct unit inspections using AFIA standards.

2.1.7.5. Coordinate MR-related inspection criteria with the office of primary responsibility (OPR) of this Instruction prior to publication or revision of AFIA inspection standards. Resolve disconnects or questions regarding the intent of guidance in advance of publication of AFIA inspection standards.

2.1.8. Air Force Personnel Center Medical Directorate (HQ AFPC).

2.1.8.1. The Directorate of Personnel (DPAM) will:

2.1.8.1.1. Maintain published guidance outlining the process for submitting applications for Category I continuing medical education (CME) and other continuing education credit for medical readiness training courses.

2.1.8.1.2. Review and approve applications for Category I CME and continuing education credit when content meets the appropriate criteria.

2.1.8.2. The Directorate of AEF Operations (DPW) Functional Area Scheduler will:

2.1.8.2.1. Identify/recommend any changes to the UTC alignment.

2.1.8.2.2. Source UTCs using Expeditionary Combat Support (ECS) Consolidated Planning Schedule (CPS), AEF Reporting Tool (ART) database, MRDSS ULTRA, Military Personnel Data System (MilPDS), vetted CBD recommendations, and applicable sourcing rule sets to include institutional forces (IF) to meet all combatant commander crisis, rotational, and individual augmentation requirements as stated in the time-phased force deployment data (TPFDD).

2.1.8.2.3. After consulting with the AFMS Functional Area Manager (FAM) use the MAJCOM coordinated and AF/SG approved Enabler battle rhythm to source Combatant Commanders' crisis response requirements, and/or AF/SG3X approved rotational taskings. It should be noted that Enablers will not be routinely made available for rotational fill, and should only be used when all other sourcing solutions have been exhausted.

2.1.8.2.4. Track residual capability and notify the force provider (HQ ACC/SGX), AFMS FAM, AF/SG3XO (Medical Operations Center), and MAJCOM FAMs when the functional area requires surge.

2.1.9. **United States Air Force School of Aerospace Medicine (USAFSAM), 711th Human Performance Wing, AF Research Laboratory, AFMC.** This organization will:

2.1.9.1. Serve as consultant/advisor to AFMS MTFs, AFRC/SG and NGB/SG on the development of memorandums of understanding (MOUs) and local training affiliation agreements for standardized training opportunities for medical-surgical services, medical support, or force enhancement personnel at civilian, Veterans Administration (VA) or Joint facilities.

2.1.9.2. Administer the Centers for Sustainment of Trauma and Readiness Skills (C-STARS) operating locations to maximize efficiency and effectiveness.

2.1.9.2.1. Collaborate with similar Joint sustainment programs for benchmarking purposes.

2.1.9.2.2. Develop new C-STARS locations as required by AF/SG3 to meet first responder, trauma care, critical care, and aeromedical evacuation personnel training requirements.

2.1.9.2.3. Oversee standardized program curricula for all C-STARS locations. Monitor these programs for quality and effectiveness, and work with the AF/SG Consultants and CFMs to update the curricula as needed. Collect student progress data every six months, at a minimum.

2.1.9.3. Provide consultative and staff assistance services to all Sustainment of Trauma and Resuscitation Skills Program (STARS-P) sites.

2.1.9.3.1. Collaborate with AETC/SG to assist MTFs to establish STARS-P programs and support associated program objective memorandum (POM) submissions as required.

2.1.9.3.2. Monitor MTF execution of STARS-P programs and establish STARS-P inspection criteria. Compile and report data on all STARS-P sites to AF/SG3X and MAJCOM/SGXs via AFMC/SG. Compile an annual training summary for AFMC/SG and AETC/SG.

2.1.9.4. Develop and conduct the CCATT Initial and CCATT Advanced UTC-specific courses, at the request of the MRA.

2.1.9.5. Provide broad oversight of the Readiness Skills Verification Program (RSVP).

2.1.9.5.1. Work with SG consultants and CFMs to ensure RSVP checklists are valid, are reviewed annually, and updated as necessary.

2.1.9.5.2. Notify personnel 30 days in advance of RSVP checklist updates, using an MRDSS ULTRA system message and the messaging functions provided by the MRDSS Community of Practice (CoP) and the AF Medical Readiness CoP.

2.1.9.5.3. Ensure AFIA inspectors are notified of changes in order to adjust RSVP inspection strategies as necessary. Personnel will normally be given six months to complete new RSVP task training unless the new tasks address a known training or capability shortfall. In such cases the consultant or CFM will provide specific guidance.

2.1.9.5.4. Post RSVP task updates in MRDSS ULTRA and on the AFMS Knowledge Exchange (Kx) only after consultant or CFM approval.

2.1.9.5.5. The governing directive for RSVP is this Instruction.

2.1.9.6. Review/evaluate new advanced clinical sustainment programs as directed.

2.1.9.7. Serve as a consultant/advisor to the AFMS on use of patient simulators and distance learning for development and sustainment of expeditionary clinical skills.

2.1.9.8. Promote medical research, particularly with expeditionary impact, across the military/civilian spectrum.

2.1.9.9. Provide technical expertise and consultative reach back capability in the areas of bioenvironmental engineering, public health and epidemiology, clinical and environmental laboratory sciences, nuclear/radiological response, and health physics support.

2.1.10. **Consultants and Enlisted Career Field Managers (CFM).** These individuals will:

2.1.10.1. Monitor, revise and support the Readiness Skills Verification Program (RSVP).

2.1.10.1.1. Determine critical knowledge and performance skills required of all deploying medical personnel and to standardize baseline AFSC skills across the AFMS. Develop, maintain, refine and validate RSVP checklist tasks and training sources.

2.1.10.1.1.1. Coordinate with MAJCOM consultants and CFMs for RSVP checklist input.

2.1.10.1.1.2. Notify the AF Expeditionary Medical Skills Institute (AFEMSI) when RSVP knowledge and performance checklists have been updated and provide implementation guidance in memo form, for dissemination to the field. The implementation memo should include, at a minimum: suggested methods for accomplishing new tasks that may exceed capabilities at some MTFs; alternate sources of training credit, such as formal course attendance or other training venues; and an implementation timeline. Typically, units will be granted six months from RSVP checklist publication to accomplish training on new tasks.

2.1.10.1.2. Collect gap analyses submitted by MAJCOM AFSC functional training managers. The gap analysis results will be divided into two types of training: local and non-local. Local training is defined as that which can be accomplished at the unit level through training affiliations or special training events. Non-local training would require AFMOA-level consultant or CFM assistance. Local items must be accomplished within established RSVP task timelines. Non-local items must be completed within 24 months of unit submission of the gap analysis to the appropriate AFMOA POC. All RSVP training must be complete prior to individuals entering their deployment vulnerability windows and proficiency verified prior to actual deployment.

2.1.10.1.3. Maintain a list of potential training sources and identify cost-effective methods for accomplishing RSVP non-local training gap items to MAJCOM and unit AFSC Functional Training Managers.

2.1.10.1.4. Work with USAFSAM to reconcile RSVP tasks and mitigate training shortfalls.

2.1.10.1.5. Reference paragraph 6.3.1 of this Instruction for additional RSVP guidance.

2.1.10.2. Consultants and CFMs for LS/HD specialties will support Consultant Balanced Deployments (CBD) processes.

2.1.10.2.1. Work with the AEF Operations Center and the CBD Liaison to generate and maintain a list of available LS/HD deployers in MRDSS ULTRA. Prioritize personnel in accordance with the AFMS Prioritization and Sequencing Guidance. The prioritized lists will be coordinated electronically, within MRDSS ULTRA, with the affected MAJCOM/SGXs and units well in advance of the AEF sourcing start date. In addition, consult with HQ ACC/SGX, the AFMS leader for developing ground base medical force and capability sourcing solutions.

2.1.10.2.2. Identify training requirements for prioritized FFZZZ personnel and notify the parent MAJCOM/SGX. Facilitate training slot assignments as necessary. Identify special training requirements, such as C-STARS, for individuals tasked or identified to deploy based on tasking authority requirements for anticipated deployment location or operational role (see paragraph 6.3.2).

2.1.10.2.3. Review personnel UTC assignments and recommend to MAJCOM/SGXs and unit commanders realignment of personnel within the AEF construct for LS/HD specialties where required, maximizing use of personnel from the same facility to fill UTCs. Recommend individuals from other MAJCOMs to complete the UTC or fill a unit line number (ULN) requirement for an AEF rotation at execution only when necessary.

2.1.10.2.4. Throughout the process, mitigate risk to overall deployment and home station missions through effective management of available deployers.

2.1.11. **Component Numbered Air Force (C-NAF) Surgeons.** These individuals will:

2.1.11.1. Provide medical expertise and input to deliberate and crisis planning operations.

2.1.11.1.1. Determine operational and rotational UTC deployment requirements and enter them into the TPFDD.

2.1.11.1.2. Coordinate changes in operational requirements with AF/SG3X to facilitate sourcing.

2.1.11.1.3. Periodically review and validate plan requirements as part of the MRL process.

2.1.11.2. Execute medical readiness missions in support of C-NAF and Combatant Command theater plans.

2.1.11.2.1. Comply with Joint and Air Force deployment guidance and deconflict operational guidance as needed.

2.1.11.2.2. Provide IHS capability (AD or ARC) in support of theater health engagement activities.

2.1.11.3. Assess effectiveness of deployed medical operations using the checklist provided in Attachment 9 of this Instruction.

2.1.11.3.1. Conduct periodic assessments of deployed MTFs. MTFs in enduring operations for more than two years with permanent (365 days) MDG/CCs (and other facilities as deemed appropriate by the C-NAF/SG) will be assessed. Scheduling is subject to Combatant Commander (CCDR) approval and Area of Responsibility (AOR) activity.

2.1.11.3.2. C-NAF/SG staffs will conduct the assessments, relying upon subject matter expertise from outside agencies, including AFIA, AFMOA, HAF, MAJCOM, and/or MRA, as required, to fill specifically identified functional knowledge gaps.

2.1.11.4. Evaluate Building Partnerships (BP), Building Partnership Capacity (BPC), and Stability Operations against developed measures of effectiveness.

2.1.11.5. Ensure lessons learned are identified via Joint Lessons Learned Information System (JLLIS) to inform higher headquarters of capability gaps and deficiencies that may require changes to existing organize, train, and equip policies and functions.

2.1.12. **Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies**. MEFPAK Responsible Agencies (MRAs) will comply with all MEFPAK requirements identified in AFI 10-401 and AFI 41-209, *Medical Logistics Support.* In addition, the MRAs will:

2.1.12.1. Develop and maintain UTCs to meet operational requirements. Appoint pilot units for each UTC. Pilot units may be medical organizations outside the MRA with coordination of the gaining MAJCOM/SG.

2.1.12.2. Prepare a playbook for each UTC, consolidating incremental UTCs into a single playbook for each medical force package, as appropriate. The playbook will serve as a consolidated resource for all information regarding the UTC, to include: personnel and equipment detail; mission capability; concept of operations (CONOPS); tactics, techniques, and procedures (TTP); individual UTC weapons and arming requirements; mission essential task lists (METL); and UTC modernization and funding information. Playbooks will be posted on the MRA CoP.

2.1.12.3. Prepare an annual status report on assigned UTCs. This report, prepared in a manner prescribed by the AF/SG should include current status of on- hand systems and personnel, modernization efforts and concerns, and is forwarded on a schedule established by the AF/SG.

2.1.12.4. Manage WRM UTCs and support requirements, to include support of WRM Consolidated Storage and Deployment Center (CSDC) operations; verification of CCDR deployment taskings; recommendations and input to WRM spend plan process; and training/exercise requirements. Participate and support WRM CSDC operations in accordance with established MOUs.

2.1.12.4.1. Verify CCDR requirements and task assets for deployment as necessary in coordination with the CSDC WRM managers and associated wing installation deployment officers.

2.1.12.4.2. Coordinate requests to store and manage additional UTCs at CSDC locations with the Air Force Medical Logistics Office (AFMLO), AFMOA/SGALX.

2.1.12.4.3. Maintain control, oversight, configuration management, and tasking authority for WRM managed and maintained at the CSDCs.

2.1.12.4.4. Coordinate with AFMSA/SGX and AFMOA/SGALX all requests to deploy a WRM UTC for training or exercise.

2.1.12.4.5. Provide recommendations and input to the WRM spend plan process to ensure appropriate funding to support sustainment, reconstitution, and production requirements of consolidated WRM.

2.1.12.5. Develop training requirements for each UTC or force package, and identify funding requirements for training and exercises to the RTOC and AFMSA/SGX as appropriate.

2.1.12.6. Plan and coordinate operational tests as necessary for the possible fielding of UTC, force packages, or installation response equipment with the pilot unit, other MAJCOM/SGXs, AFMSA/SGX, AFMSA/SGR, or operational test agencies, as

appropriate. Identify procurement and sustainment lifecycle costs in coordination with AF/SG3X and AFMSA/SGX.

2.1.12.7. Coordinate with appropriate joint training agencies, Air Force agencies, and MAJCOM/SG to ensure that AFMS participates in major training exercises, including Joint Chiefs of Staff (JCS) exercises, in accordance with AFMS guidance.

2.1.12.8. Provide oversight and guidance to pilot units.

2.1.12.8.1. Identify pilot unit responsibilities in writing, outlining processes associated with program modernization or enhancements.

2.1.12.8.2. Ensure pilot units review UTC weapons requirements annually. Update the Weapons and Munitions Forecasting Table for AFMS UTCs on the Medical Readiness CoP, as necessary.

2.1.12.9. Fully coordinate all UTC development, changes, and cancellations with all using commands.

2.1.12.10. Ensure medical readiness requirements are represented in Combat Air Forces/Mobility Air Forces/Special Operations Forces (CAF/MAF/SOF) and AFMS strategic planning; AFMS sponsored medical modernization Research and Development efforts; AFMS and Line Program Objective Memorandum development/deliberations; integrated product teams and High Performance Teams capability gaps and requirement identification.

2.1.12.11. As the MRA for MC-CBRN, ACC will develop and maintain AFTTP 3-42.32, *Home Station Medical Response to CBRN Events* and oversee MC-CBRN allowance standard (AS) pilot unit activities.

2.1.13. **Major Command Surgeons (MAJCOM/SG) and National Guard Surgeon (NGB/SG).** These individuals will:

2.1.13.1. Provide guidance and assistance to subordinate units on all aspects of medical readiness.

2.1.13.2. Ensure that medical units are properly organized, trained, and equipped to carry out all aspects of their expeditionary and HA/DR missions in accordance with AF War and Mobilization Plan, Vol. 1 (AF WMP 1) guidance, Operation Plan (OPLAN) requirements and other applicable directives. For ARC units, this is additionally a gaining MAJCOM responsibility in accordance with AFI 10-301, *Responsibilities of Air Reserve Component (ARC) Forces*.

2.1.13.3. In concert with AFMOA, ensure each subordinate medical unit's manning document (UMD) is postured to balance readiness, business case, and clinical currency requirements.

2.1.13.4. Provide supporting guidance to assist with the implementation of AF guidance on expeditionary and HA/DR operations, training, and assessment.

2.1.13.5. Appoint a Public Health Officer (PHO) as the functional expert for Biological Warfare (BW) Disease Surveillance and Epidemiological response.

2.1.13.6. Appoint a Medical Corps Officer with experience in preventive medicine and/or emergency response, such as the assigned Chief of Aerospace Medicine (SGP), as the MAJCOM Public Health Emergency Officer (PHEO). Reference AFI 10-2603, *Emergency Health Powers on Air Force Installations* for additional guidance.

2.1.13.7. Provide oversight to the MAJCOM/SGX office (or standing force headquarters equivalent) in the performance of the following tasks:

2.1.13.7.1. Assist medical readiness officers (MROs), medical readiness NCOs (MRNCOs), and civilian medical readiness managers (MRMs) in resolving issues with their units' readiness programs.

2.1.13.7.2. Ensure force health protection guidelines for each area of responsibility are available to subordinate units.

2.1.13.7.3. Review unit Medical Contingency Response Plans (MCRPs) prior to publication to verify compliance with AF directives. Ensure each team annex in the MCRP includes specific MC-CBRN response procedures, whether using assigned MC-CBRN assemblages or available resources. Reviews must be completed within 60 days of submission by the unit or concurrence is implied.

2.1.13.7.4. Collect and evaluate readiness guidance change requests from units and other subordinate organizations. Submit consolidated requests to AFMSA/SGX.

2.1.13.7.5. Coordinate with MRA as necessary regarding input to UTC manning, equipment, and training requirements.

2.1.13.7.6. Monitor MRDSS ULTRA data to identify personnel, training, and equipment/supply trends, shortfalls and gaps.

2.1.13.7.7. Identify MAJCOM MR program resource requirements for inclusion in the MAJCOM/SG POM and Execution Year budget submission. Additionally, notify the AF/SG MR Panel of resource requirements.

2.1.13.7.7.1. Advocate to AF/SG3X and the MAJCOM FM for resources associated with LAF funded MR programs.

2.1.13.7.7.2. Coordinate with other functional experts on MR resource requirements, as necessary.

2.1.13.7.7.3. Ensure MAJCOM PEM for LAF PE 28036F, MC-CBRN Program, rests with the MAJCOM/SGX office (or standing force headquarters equivalent).

2.1.13.7.7.4. Elevate MAJCOM or unit MC-CBRN issues that require higher headquarters involvement to the MC-CBRN Oversight Committee for resolution.

2.1.13.7.8. Coordinate and submit consolidated exercise requirements to the RTOC. Designate MAJCOM representatives to the RTOC to provide input to training and exercise priorities and schedules, and ensure unit participation prior to AEF vulnerability periods.

2.1.13.7.9. Coordinate Operational Readiness Inspections (ORI), Compliance Inspections (CI) and other MAJCOM directed inspection activities with the MAJCOM inspection OPR.

2.1.13.7.10. Provide program oversight for MC-CBRN at the MAJCOM level to include distribution of MC–CBRN funding and other resources to help installation close capability gaps identified in 2.1.13.7.6.

2.1.13.8. Designate a MAJCOM/SGX representative to provide MRDSS ULTRA support to MRDSS ULTRA Unit System Administrators. The MAJCOM MRDSS ULTRA representative will create, review, and delete MRDSS ULTRA Unit System Administrator user accounts, as appropriate, and ensure positive control of sensitive information contained within MRDSS ULTRA. This individual will provide assistance and guidance to Unit System Administrators with data entry and contact the MRDSS Help Desk if technical assistance is required.

2.1.13.9. Support the CBD process by coordinating on consultant/CFM deployment planning prioritized lists. Forward recommendations to the medical unit commanders for review and negotiation with consultants before final approval.

2.1.13.10. Appoint a MAJCOM Functional Area Manager(s). This individual/office will:

2.1.13.10.1. Manage the apportionment of MAJCOM UTCs in close coordination with AF/SG3X, utilizing the MRL.

2.1.13.10.2. Ensure accuracy of AEF libraries and the UTC Availability (UTA) database. Update individual unit Status of Resources and Training System (SORTS) Designed Operational Capability (DOC) Statements as changes occur.

2.1.13.11. Appoint MAJCOM representatives to the MC-CBRN OC addressed in paragraph 2.1.6.6.

2.1.14. **Air Education and Training Command Surgeon (AETC/SG).** AETC/SG will support STARS-P by:

2.1.14.1. Coordinating with AF/SG to obtain on-site simulators and qualified simulator staff to execute STARS-P training.

2.1.14.2. Providing oversight of contracted simulation personnel at STARS-P sites.

2.1.14.3. Directing AETC/SGR to:

2.1.14.3.1. Provide expertise and a recommended equipment and supply list needed to establish a simulation facility.

2.1.14.3.2. Develop simulation curriculum and scenarios in support of program objectives and requirements.

2.1.15. **882nd Training Group (TRG) (AETC) and Alpena Medical Readiness Training Site (ANG).** These organizations will:

2.1.15.1. Develop and conduct UTC-specific courses at the request of the MRA and include the field training topics listed in Attachment 3, Table A3.5. **Note:** USAFSAM is responsible for the CCATT Initial and CCATT Advanced UTC-specific courses.

2.1.15.2. Obtain approval of curriculum content for medical readiness training courses and UTC-specific courses from AF/SG through the MRAs, and the RTOC prior to implementation.

2.1.15.3. Coordinate with HQ AETC/SGNU for technical training courses.

2.1.16. **Medical Unit Commander.** The commander will:

2.1.16.1. Review UTCs apportioned to the unit in the approved MRL annually, or whenever there is a change, and document the review in the next set of MRC/EMC minutes. The Unit MRL Information - Current Year Taskings in the official approved MRL can be viewed in MRDSS ULTRA.

2.1.16.2. In coordination with the medical unit 3-letter functional advisors, unit-assigned senior enlisted functional managers, and the MR office, ensure qualified personnel are assigned to UTCs.

2.1.16.3. Ensure a process is in place to verify pre- and post-deployment medical screening and immunization requirements for all deploying forces (medical and non-medical) are identified and completed in accordance with current DOD policies. This includes, but is not limited to, preventive health assessments (PHA), medical and dental screening, and support to the installation deployment processing line.

2.1.16.4. Support the CBD process by reviewing UTC assignment rosters, the deployment planning prioritized list, and personnel availability codes provided by the MR office. Review tasking recommendations from consultants/CFMs and MAJCOM/SGXs, and concur or non-concur as appropriate.

2.1.16.5. Support the units MR plans program.

2.1.16.5.1. Direct the MR office to develop and publish the unit's MCRP. Approve the MCRP for publication after full coordination with contributing agencies/organizations/functions, review and approval by the MRC, and review by the parent MAJCOM/SGX. ARC collocated medical units need not prepare an MCRP but must ensure their capabilities are included in the MCRP of collocated active duty MTFs. In lieu of an MCRP, non-collocated ARC units, limited scope (LS) MTFs, and limited scope with inter-service support (LSISS) MTFs will incorporate MCRP concepts, unit capabilities and procedures into base level plans.

2.1.16.5.2. Establish, evaluate and maintain the capability to provide and/or arrange for emergency care and transport of casualties resulting from medical contingencies consistent with the unit’s mission.

2.1.16.5.3. Approve installation medical emergency management Memorandum of Understanding/Memorandum of Agreement/Mutual Aid Agreements (MOU/MOA/MAAs) with military and civilian agencies identified in the MCRP, ensuring all medical capabilities necessary to fully execute all installation plans are included. Ensure coordination of agreements through Base Legal Office and an annual review by the MRC.

2.1.16.6. Establish, organize, and maintain the Medical Control Center (MCC) as an operational location.

2.1.16.7. Establish and maintain MC-CBRN capabilities in accordance with AFTTP 3-42.32, and this Instruction, organically within the medical organization; through written MOU/MOA/MAAs with other organizations in the local area; or through a combination of these methods. Ensure participation in higher headquarters exercises, such as All

Hazards Response Training (AHRT). Train, exercise, equip, and budget to meet the following MC-CBRN program requirements:

2.1.16.7.1. Decontaminate patients prior to entry into the MTF. At the beginning of an emerging incident, CBRN contamination screening of patients/casualties must be initiated to protect the medical facility and its staff. Reference Chapter 7 of this Instruction for additional guidance.

2.1.16.7.1.1. Additional information on ANG decontamination capability is provided in Chapter 10 of this Instruction.

2.1.16.7.1.2. Decontamination requirement is not applicable to AFRC medical units.

2.1.16.7.2. Triage, stabilize, transport, and track casualties, to include behavioral casualties. Installations must plan to provide treatment using existing medical unit resources and MC-CBRN assets which provide supplies for up to 300 casualties. In addition, medical units must consider medical assets organic to other installation units and assets available from off-base agencies in accordance with MOU/MOA/MAA. Planning will include procedures and lines of communication for a collaborative community or unified response. However, the medical unit must still plan for closed-base operations without assistance in the early phases of an incident when augmenting capability may be unable to assist. This may be up to 96 hours without adequate augmentation, though each medical unit must consider local threats, capabilities and conditions when planning early phase duration. Ensure public health emergency surge requirements are addressed in Annex E of the MCRP in accordance with DODI 6200.03, Enclosure 4. For ANG units, provide stabilization for 100 patients) until assistance is provided. (Not applicable to AFRC medical units.)

2.1.16.7.3. Develop mass prophylaxis (vaccination, medications, etc.) plans and procedures based on credible threats or events. (Not applicable to ARC medical units.)

2.1.16.7.4. Conduct threat-based health risk assessments, to include CBRN sampling, testing, dose estimation, and medical countermeasures. Conduct threat characterization and assessment to assist commanders in operational risk management decision-making. For AFRC, the OPR for MC-CBRN is the full-time BE or Public Health office, which is aligned under the Mission Support Group or Wing, versus the medical unit.

2.1.16.7.5. If the MTF's laboratory is certified under the DOD Center for Clinical Laboratory Medicine (CCLM) as a base sentinel site for microbiology, ensure participation in the Centers for Disease Control and Prevention (CDC) Laboratory Response Network (LRN) as a Basic Sentinel site. Laboratories registered to perform high-complexity microbiology testing will serve as Advanced Sentinel sites and will be capable of ruling out the presence of *Bacillus anthracis, Brucella abortus, Burkholderia mallei, Burkholderia pseudomallei, Fransciella tularensis, and Yersinia pestis* in clinical specimens, adhering to CDC protocols.

2.1.16.7.6. Establish, or have access to through signed agreement, a laboratory facility/building outside or separate from the medical facility for receipt and

processing of environmental samples, to avoid introduction of potential contaminants into the medical facility. See Chapter 7 for additional facility options. (Not applicable to ARC medical units).

2.1.16.7.7. Monitor HSMR data to assess local capability and risk associated with gaps and to determine corrective actions. Contribute to integrated installation response capability assessments at the installation level.

2.1.16.8. Establish an effective medical readiness training program.

2.1.16.8.1. Ensure assigned personnel meet mission training requirements in accordance with AOR reporting instructions, AFI 10-401, AFI 10-403, AFI 36-2201, *Air Force Training Program,* and this Instruction.

2.1.16.8.2. Direct the MR office to prepare and maintain the Annual Medical Readiness Training and Exercise Schedule (MRTES) and submit it to the MRC/EMC for review and approval prior to the start of the next calendar year.

2.1.16.8.3. Ensure individuals and teams receive all training required to be mission ready in accordance with AF policy. Conduct training at the unit level when required.

2.1.16.8.4. Approve or disapprove individual requests for RSVP training credit for deployments or exercises, based on the AFSC functional training manager's recommendation. Approval may be delegated to subordinate commanders.

2.1.16.9. Provide an assessment of the unit's readiness to perform its tasked missions, in ART, DRRS ESORTS, and in SORTS, as required.

2.1.16.10. Chair the MRC (or EMC). Approve the agenda and meeting minutes. Ensure required attendance and identify additional participants. Establish the MC-CBRN working group as described in AFTTP 3-42.32.

2.1.16.11. Designate qualified individuals to perform the following emergency management functions, in accordance with DODI 6200.03, *Public Health Emergency Management within the Department of Defense*:

2.1.16.11.1. Coordinate planning and preparedness and execution of all-hazards emergency management activities on behalf of the medical unit commander.

2.1.16.11.2. Act as primary medical point of contact with the Installation Emergency Manager and serve as medical unit lead for military/civilian emergency management coordination.

2.1.16.11.3. Ensure threat information, vulnerability assessments, and associated mitigating actions are considered in executing medical unit emergency management activities.

2.1.16.11.4. Serve as the primary advocate to identify resource needs to execute emergency management mission requirements.

2.1.16.11.5. Training and additional information may be obtained from the following: Air Force Emergency Response Operations (AERO) Course, available through the Advanced Distributed Learning System (ADLS); CBRNE Emergency Preparedness Response Course (EPRC) J3OP-US260, Operator-Responder Course,

available through Joint Knowledge Online (JKO); Defense Support of Civil Authorities (DSCA) Phase 1 Parts 1, 2, and 3, Courses J3ST-US010-1, J3ST-US010-2,and J3ST-US010-3, available through JKO; and the Joint Public Health Emergency Management (PHEM) Course provided by the Defense Medical Readiness Training Institute (DMRTI), in residence.

2.1.16.12. Appoint, in writing, a primary and alternate for each position below:

2.1.16.12.1. MRO, MRNCO, and/or MRM, as appropriate. See Chapter 3 for additional guidance.

2.1.16.12.2. Unit Medical Readiness Training Manager. See paragraph 3.2.4 for additional guidance.

2.1.16.12.3. AFSC Functional Training Manager for each assigned AFSC. See paragraph 2.1.24 for additional guidance.

2.1.16.12.4. MCRP Team Chiefs. See paragraph 2.1.22 for additional guidance.

2.1.16.12.5. Medical Exercise Evaluation Team (EET) Chief and EET members, in accordance with local requirements. Select sufficient members to evaluate the full scope of unit medical operations. Members should serve for a minimum of one year. See chapter 8 for additional guidance.

2.1.16.12.5.1. Commanders should select EET members based on functional expertise, ability, and maturity, and ensure they meet wing training requirements.

2.1.16.12.5.2. Deployed MTF commanders should appoint EET members from each AEF rotation to ensure medical requirements are addressed in wing/base/installation exercise scenarios and to evaluate medical response, as appropriate.

2.1.16.12.6. Unit Deployment Manager (UDM). See paragraph 3.2.1 for additional guidance.

2.1.16.12.7. Unit Plans Officer/NCO. See paragraph 3.2.2 for additional guidance.

2.1.16.12.8. Unit Reports Monitors, including unit SORTS monitor, DRRS ESORTS monitor, and ART monitor. See paragraph 3.2.3 for additional guidance.

2.1.16.12.9. MRDSS ULTRA Unit System Administrator. See paragraph 3.2.5 for additional guidance.

2.1.16.12.10. Medical representatives to the installation's Emergency Operations Center (EOC).

2.1.16.12.11. Medical representatives for Emergency Support Functions (ESF) 8 and ESF 11. These individuals will also be Office of Coordinating Responsibility (OCR) for other ESFs, and therefore must be highly knowledgeable and have decision-making authority. In addition to ESF training required by the installation, medical ESF representatives should maintain an expert level of knowledge of the installation Comprehensive Emergency Management (EM) Plan (CEMP) 10-2, the MCRP, and local MTF capabilities. Additional information on the ESFs is available in AFI 10-2501 and AFMAN 10-2502, *Air Force Incident Management System (AFIMS)*

Standards and Procedures. For AFRC installations, primary ESF 8 and 11 representatives will be designated from the full-time BE or Public Health offices. For LS and LSISS MTFs, one individual may serve all of the above functions, as necessary.

2.1.16.12.12. UTC Team Chiefs or UTC Family Group Leaders, at the discretion of the commander, plus alternates. See paragraph 2.1.23 for additional guidance. **Note:** The Patient Decontamination Team, UTC FFGLB, requires the appointment of a UTC team chief and NCOIC. Additionally, Pilot Units are required to appoint team chiefs and alternates for their pilot UTCs.

2.1.16.12.13. Deployment Processing Support Team members. Depending on facility size and deployment mission, this team will consist of representatives from the following functional areas to support pre-deployment activities: outpatient records, pharmacy, medical logistics, physical exams, immunizations, the public health officer (medical intelligence), mental health, and dental.

2.1.16.12.14. Reserve Affairs Liaison. See paragraph 10.2.2 for additional guidance.

2.1.16.12.15. For AFRC, an Education and Training office of responsibility (OPR).

2.1.16.12.16. For NDMS-FCC facilities (Not applicable to ARC units):

2.1.16.12.16.1. An FCC Coordinator. This individual is responsible for the management of the day-to-day operations and the alert and activation of the FCC and associated NDMS Patient Reception Areas (PRAs).

2.1.16.12.16.2. An FCC Director (MDG/CC or other principle staff member to whom the MDG/CC has delegated the duty). This individual is responsible for the management and execution of the FCC mission and associated NDMS PRAs IAW DODD 6010.22.

2.1.16.13. Manage funds for the unit's medical readiness program.

2.1.16.13.1. Collect all applicable costs related to specific contingency operations or other military operations, and report these costs in accordance with AF/SG8 guidance.

2.1.16.13.2. Limit Defense Health Program (DHP) funding for non-combat support medical activities, to include organizing, training, and equipping medical personnel. **Note:** DHP funds should be used for maintaining RSVP and for other skills inherent to individual medical capabilities.

2.1.16.13.3. Identify training and exercise funding requirements to the wing commander and parent MAJCOM/SG.

2.1.16.13.4. Abide by rules regulating appropriated DOD line funds when planning exercises and conduct exercises at home station to the greatest extent possible. Exceptions are limited to those exercises planned and programmed for by the RTOC.

2.1.16.13.5. Fund participation in CCDR-directed operations with appropriations specifically provided to the CCDR for such purposes. Medical units may not use Defense Health Program (DHP) appropriations for CCDR-directed activities.

2.1.16.13.6. Provide oversight of MC-CBRN funding as addressed in paragraph 3.2.6.1.

2.1.16.13.7. Consult MAJCOM resource managers for funding activities with ARC units or personnel.

2.1.16.14. For units possessing WRM assemblages, ensure the appropriate personnel UTCs operationally test the equipment annually. Operational testing will involve team members and is defined as full set-up, turning equipment on, validating that all the necessary pieces are available and in working condition, and re-packing the assemblage for potential future operational use.

2.1.16.14.1. If the MTF maintains WRM assemblages for other units (e.g. Red Horse, SME, or AE) provide opportunities for those units to train, exercise with and operationally test the equipment. However, the medical unit is not responsible for ensuring that training, exercising and operational testing is accomplished. When possible, these events should be discussed in the MRC/EMC to support project oversight.

2.1.16.14.2. When the base is host to ARC or other Active Duty units with similar personnel UTCs, ensure the tenant or supporting units are given the opportunity to train with the host unit's UTCs; however those units have ultimate responsibility for operationally testing their own equipment, if possessed. Refer questions to the appropriate MEFPAK responsible agency (MRA) through the parent MAJCOM.

2.1.16.15. STARS-P host MTF/CCs will:

2.1.16.15.1. Retain command and control and resourcing authority over assigned personnel.

2.1.16.15.2. Sustain STARS-P platforms in accordance with AFEMSI guidance; identify resource requirements, such as manpower, simulator repair/parts and funding, and submit to AF/SG8 for inclusion into the POM process.

2.1.16.15.3. Obtain and replace supplies and consumables except for new simulators. Provide space for simulation facilities based on guidelines from AETC/SGR. Provide an Education and Training function that will exercise oversight responsibility for execution of the STARS-P program.

2.1.16.15.4. Ensure the MTF Education &Training (E&T) staff assists simulation management personnel to perform a training needs assessment to determine institutional training shortfalls. E&T staff will ensure AFEMSI guidance and institutional training requirements guide STARS-P utilization and will assist with scheduling staff and/or teams for training. Personnel will be identified for training by the E&T in accordance with the training schedule prepared by simulation management staff.

2.1.16.15.5. Resolve licensure issues locally with each Training Affiliation Agreement (TAA) in coordination with USAFSAM and AF/SGJ.

2.1.16.16. Special Command Considerations. Policy guidance for commanders of Limited Scope (LS), Limited Scope with Inter-service Support (LSISS), and deployed MTFs may differ from that provided in the preceding paragraphs. Specific provisions for these units are provided in Chapters 4, 5, 6, 7 and 8 of this Instruction.

2.1.16.16.1. LS MTFs are defined as units with less than 75 assigned personnel. LSISS MTFs are tenant units on bases where at least two Services share resources. Joint base MTFs that are host units are not considered LSISS MTFs.

2.1.16.16.2. Deployed MTFs. Any AF medical facility established in response to a contingency situation may be termed a deployed MTF by HQ AF/SG.

2.1.17. **Medical Unit MRO, MRNCO, and MRM.** These individuals will be referred to collectively as the MR office unless a paragraph addresses one individual specifically. The MR office will:

2.1.17.1. Schedule and coordinate the agenda for MRC/EMC meetings in accordance with this Instruction. ARC will ensure required material is provided to the EMC at least quarterly.

2.1.17.2. Coordinate and publish the MCRP according to requirements outlined in Chapter 5 of this Instruction.

2.1.17.3. Provide medical input to applicable base level plans, incorporating MCRP concepts and procedures as appropriate. With the assistance of the PHO and Bioenvironmental Engineer (BEE), ensure the medical input includes current and potential medical risks or threats. ARC units will document their expeditionary missions in the parent wing mobilization plan and their homestation response missions and capabilities in base level emergency management plans.

2.1.17.4. Develop, coordinate and maintain copies of medical readiness MOAs/MOUs/MAAs with the appropriate off-base agencies.

2.1.17.5. Develop the MRTES, incorporating all training and exercise requirements described in this Instruction in an executable format and timetable, covering a 24 month period. Include unit developed readiness training programs under local purview and Wing training schedules as available. This planning tool may be adjusted as training and exercise opportunities become available or are rescheduled throughout the 24 month period. A sample MRTES format is provided on the AF Medical Readiness CoP.

2.1.17.6. Coordinate and schedule UTC-specific training for personnel assigned to UTCs that have courses.

2.1.17.7. Collect documentation for UTC sustainment training equivalency credit for exercise participation from individuals returning from an MRA-approved exercise. Enter the exercise return date as the new training completion date for associated training items.

2.1.17.8. Ensure medical readiness training is properly documented in MRDSS ULTRA in accordance with this Instruction.

2.1.17.9. Chair the MC-CBRN Working Group as a sub-committee to the MRC. Provide oversight of the unit's MC-CBRN program and assist MCRP team chiefs with the management, training, planning, and staffing functions of their teams. See paragraphs 3.2.6 and 3.2.7 for additional guidance.

2.1.17.10. Conduct medical operational readiness reporting in accordance with AFI 10-201, *Status of Resources and Training System (SORTS)*, AFI 10-206, *Operational Reporting*, and AFI 10-244, *Reporting Status of Aerospace Expeditionary Forces*.

2.1.17.11. Monitor the status of assigned WRM assemblages through MRDSS ULTRA and obtain data from medical logistics staff, as necessary, to complete readiness report remarks and brief the unit commander and the MRC/EMC.

2.1.17.12. Support CBD by providing accurate UTC assignment rosters, deployment availability data, AFSC substitutions, and concur or non-concur recommendations to the unit commander during the deployment planning prioritization coordination process in MRDSS ULTRA. When submitting a non-concur, select appropriate remarks/rationale from the drop-down list.

2.1.17.13. Identify unit MR program resource requirements for inclusion in parent MAJCOM POM process and execution year budget submission. Advocate, in conjunction with the resource management office, to the MAJCOM/SGX and installation FM for resources associated with LAF funded installation response programs. Coordinate with other functional experts as required (BEE, PHO, medical logistics, etc.) on MR resource requirements.

2.1.17.14. Integrate medical readiness portions of the AFIA Health Services Inspection (HSI) Guide and key elements from this Instruction into the unit self-inspection program. Brief the MRC/EMC on self-inspection results as appropriate.

2.1.17.15. Ensure all MR-related appointment letters are current and maintained as required.

2.1.17.16. When officially appointed as part of the VA/DoD Contingency Hospital System, oversee Federal Coordinating Center (FCC), Primary Receiving Center (PRC) or Secondary Support Center (SSC), ensuring all planning actions are accomplished IAW published NDMS/VA/DoD Contingency Hospital System guidance.

2.1.17.17. Serve as MTF commander's liaison with the senior member of the deployment processing support team.

2.1.18. **Public Health Officer (PHO) (43HX)/Public Health NCOIC (PHNCO) (4E071/4E091).** This individual will:

2.1.18.1. Perform medical intelligence functions. For AFRC installations, the full-time BE/Public Health office is responsible for providing the operational medical intelligence briefings and carrying out the responsibilities in this paragraph. These responsibilities shall be accomplished in cooperation with the Reserve Medical Unit (RMU).

2.1.18.1.1. In support of wing deployment operations, work with LAF intelligence personnel, National Center for Medical Intelligence (NCMI), and parent MAJCOM/SGPM personnel to obtain a medical intelligence assessment to include health threats from infectious disease, poisonous/venomous flora and fauna, disease

risks, environmental health hazards, industrial hazards, host nation medical capabilities/facilities, cultural-specific health issues unique to the host nation population, and host nation CBRN warfare medical defense capabilities. Use available medical intelligence sources to prepare the medical threat assessments at deployment locations. Use this data to provide medical intelligence/force health protection briefings to all wing deploying forces during base deployment processing. During the post-deployment phase, provide input to the after action report (AAR).

2.1.18.1.2. Provide a medical intelligence briefing to the MRC/EMC upon request of the commander or receipt of a tasking to a new deployment location. This briefing will include assessment of local threats, threats to potential deployment sites, current information on vaccines and antidotes, possible disease surveillance trends, and in coordination with the BEE, the capabilities to identify CBRN threats and the limitations to protective measures, if any. Utilize appropriate procedures for briefing and controlling classified information.

2.1.18.1.3. For units without a PHO/PHNCO, contact the Command PHO for guidance.

2.1.18.1.4. For AFRC, units tasked with the Aerospace Medicine Function (FFDAF, FFDAG, FFDCC, FFDCD, and FFABC UTCs) will be responsible for this duty in conjunction with their AD Public Health Host. Individuals performing this duty may be assigned to another collocated reserve unit. At AFRC installations, the PH functions are performed by full-time BE/PH personnel, who align under the Mission Support Group or Wing (and not the RMU) at AFRC host locations, in cooperation with the full time RMU staff and UTC tasked traditional reservists (TR).

2.1.18.2. Attend Contingency Preventive Medicine (CPM) Course, #B3OZYCONOP-000 and the Introduction to Medical Intelligence Course located at the NCMI, Ft. Detrick, MD. The Public Health Apprentice, Officer, or NCMI course may be attended in lieu of the CPM Course for ARC personnel performing medical intelligence functions.

2.1.18.3. Serve as a functional advisor to the MR office for planning, training, and execution of the unit installation contingency response program.

2.1.18.4. Collaborate with the PHEO regarding public health activities that identify and mitigate the consequences of a CBRN incident.

2.1.18.5. Collaborate with local off-base public health officials on CBRN threat response and epidemiological investigations.

2.1.18.6. Perform food vulnerability assessments to support planning and recommended corrective actions in anticipation of, and in response to, a CBRN event. Perform initial testing of foods suspected of deliberate bacterial contamination and collaborate with Office of Special Investigation (OSI), Security Forces Squadron (SFS), Laboratory Biological Detection Team (LBDT), and PHEO to determine an appropriate course of action.

2.1.18.7. Conduct medical surveillance and epidemiological investigations of the installation population and beneficiaries for sentinel events, diseases, and adverse health effects due to CBRN events. Ensure medical surveillance, conducted in accordance with AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance* and AFI 10-2603, includes baseline health surveillance to assist in detecting a CBRN event (not applicable to ARC medical units).

2.1.18.8. Conduct MC-CBRN risk communication to provide pre-, trans- and post-CBRN event health risk information to wing personnel and their families. Transmit, through the wing Public Affairs (PA) office, all risk communication information, intended for public release.

2.1.18.9. Serve as a POC for the Installation Force Protection Working Group, Threat Working Group, and Vulnerability Assessment Teams. Provide medical intelligence, food vulnerability assessment, site assessment, and health risk assessment information, as necessary. Provide threat information to the PHEO (ANG PHEO Liaison for ANG) as necessary.

2.1.18.10. As MCRP Public Health Team Chief, manage and maintain the 886P AS.

2.1.18.11. For AFRC installations, the full-time BE/Public Health office is responsible for ensuring the RMU has the required full-time public health support to accomplish the requirements in paragraphs 2.1.18.4-9.

2.1.19. **Bioenvironmental Engineer (BEE) (043E3) or a BE Technician (4B071).** This individual will:

2.1.19.1. Provide hazard identification, evaluation, and control capabilities, and execute health risk assessment to recommend appropriate courses of action to commanders pre-, trans-, and post-incident. Additionally, collaborate with public health personnel to conduct MC-CBRN risk communication to wing personnel and their families during all stages of the incident. Document health risk assessment information in the Occupational & Environmental Health-Management Information System (OEH-MIS) (e.g. Incident Reporting Module). Health risk assessments for non-occupational worker responder(s) may also be annotated within the IR section of OEH-MIS. Reference AFI 10-2501 and AFI 10-2603 for additional guidance.

2.1.19.2. Serve as a functional advisor to the MR office for planning, training, and execution of the unit installation contingency response program as well as CBRN issues. The BE office may assist in verifying trainers are qualified to conduct for First Responder Awareness Level and First Responder Operations Level Training for Hospital-Based First Receivers (initial and refresher) or in finding training from an outside source.

2.1.19.3. Attend the Bioenvironmental Engineering Emergency Management and Response (BEEMR) Course, (BEEMR I – distance learning, no course number)(BEEMR II Enlisted – B3AZY4B0X1 0A1A, BEEMR II Officer – B3OZY43E1 0A2A), if not previously attended. Members who have attended the former MNBC course are not required to also attend the BEEMR course. Attendance priority is given to those personnel assigned as primary members to the FFGL1 UTC. BEEs who have graduated from the Bioenvironmental Engineering Officer Course (Full Course), (B3OBY43E1 0A1A), or Bioenvironmental Engineering Officer Course (Increment 4), (B3OBY43E1

OA4A), from February 2011 and later or who have graduated from the Bioenvironmental Engineering Officer Course (Full Course), (B3OBY43E1 015), or Bioenvironmental Engineering Officer Course (Increment 4), (B3OBY43E1-019) from January 2004 to June 2010 are already awarded credit for BEEMR.

2.1.19.4. Serve as a POC for the Installation Force Protection Working Group, Threat Working Group, and Vulnerability Assessment Teams. Provide CBRN medical threat intelligence, water vulnerability assessment, Toxic Industrial Chemical/Toxic Industrial Material (TIC/TIM) vulnerability assessment, site assessment, and health risk assessment information, as necessary. Provide threat information to the PHEO (ANG PHEO Liaison for ANG) as necessary.

2.1.19.5. Conduct an annual assessment of local industrial facilities (on and off base) that may be of consequence to base operations if toxic industrial chemical/toxic industrial materials are released and report results to MRC/EMC and Wing Force Protection Working Group. Provide the PHEO any threat assessment information necessary for planning the clinical response to CBRN event (Not applicable to AFRC Reserve Medical Units). Ensure classification of appropriate data where required. Utilize appropriate procedures for briefing and controlling classified information.

2.1.19.6. Evaluate CBRN aspects of the unit's MCRP, the CEMP 10-2, and applicable MOUs/MOAs/MAAs with local health care facilities. For non-collocated AFRC units, evaluation of CBRN aspects of the CEMP 10-2, or equivalent, and applicable MOUs/MOAs/MAAs is the responsibility of the Bioenvironmental Engineering office.

2.1.19.7. Provide subject matter expertise to medical and installation commanders on CBRN effects, risks assessment, and operations in CBRN environments.

2.1.19.8. Ensure BE personnel are fully trained on response equipment and participate in proficiency analytical testing for CBRN agents as required. As MCRP BE Team Chief (or Bioenvironmental Engineering office for non-collocated AFRC units), manage and maintain the 886H AS.

2.1.19.9. Accomplish Occupational and Environmental Health (OEH) risk assessments for base responders and MCRP teams, as appropriate. Enroll personnel who are required to wear respiratory protection in the Installation Respiratory Protection Program.

2.1.19.10. Collaborate with OSI, Security Forces, and the installation Anti-Terrorism Officer to ensure evidence collected during CBRN response operations is properly preserved and protected and chain of custody requirements are met.

2.1.19.11. In a pre-attack posture, evaluate and advise on effectiveness of collective protection and appropriate Mission Oriented Protective Posture (MOPP) posture in collaboration with base Emergency Management personnel

2.1.19.12. Advise the Incident Commander (IC), as defined in AFI 10-2501, on OEH risk assessment and consultation for emergency responders and affected responders.

2.1.19.13. Implement the water vulnerability assessment program in accordance with federal, state and local regulations, AFI 48-144, *Safe Drinking Water Surveillance Program*, and AFI 10-246, *Food and Water Protection Program.*

2.1.19.14. For AFRC installations, the full-time BE/Public Health office is the OPR for the duties in paragraphs 2.1.19.1-2.1.19.13 with flight medicine support as appropriate and available from the RMU.

2.1.20. **Public Health Emergency Officer (PHEO).** The PHEO will:

2.1.20.1. Work with the BEE in the assessment of clinical capabilities and the impact of a CBRN threat, recommend appropriate actions to protect forces, and serve as an advisor to MCRP team chiefs for the treatment of CBRN casualties.

2.1.20.2. Provide the medical unit commander with guidance and recommendations on preparing for, declaring, responding to, and recovering from public health emergencies.

2.1.20.3. Comply with training requirements and conduct public health emergency management roles and responsibilities in accordance with AFI 10-2603.

2.1.20.4. Refer to AFI 10-2603 for guidance on PHEO requirements, including the ANG PHEO Liaison (PHEO-LNO) program.

2.1.21. **Medical Exercise Evaluation Team (EET) Chief.** This individual will:

2.1.21.1. Serve in the position for a minimum of 12 consecutive months after completing all training requirements. EET members will also serve for a minimum of 12 months after training.

2.1.21.2. Identify sufficient members to evaluate the full scope of unit medical operations. Train medical EET members to assist in the evaluation of medical response during unit and wing exercises.

2.1.21.2.1. Ensure appropriate EET members are trained and maintain Self-Aid and Buddy Care (SABC) instructor qualifications in accordance with AFI 36-2238, *Self-Aid and Buddy Care Training.*

2.1.21.2.2. Complete EET training in accordance with AFI 10-2501 and wing requirements.

2.1.21.3. Coordinate the base exercise schedule with medical logistics and the MRO/MRNCO. Ideally, one of the two required Terrorist Use of CBRNE exercises should be conducted 30 days prior to the annual 886 Allowance Standard (AS) inventory.

2.1.21.4. Coordinate exercise goals and objectives with the MRO/MRNCO and MCRP team chiefs. Incorporate Defense Readiness Reporting System (DRRS) Mission Essential Task (MET) requirements into exercise scenarios and evaluation criteria, ensuring all METs are tested annually, at a minimum. The official source for the METs is the AF Universal Task List, which is available on the AF Operational Readiness CoP; a medical-specific excerpt, specifically for DRRS, is available on the AF Medical Readiness CoP.

2.1.21.5. Develop at both the wing and unit levels, medical portions of exercise scenarios that fully test medical response capability.

2.1.21.6. Ensure all medical exercise requirements are met through either wing or unit exercises.

2.1.21.7. Direct medical portions of exercises according to the exercise schedule of events.

2.1.21.8. Evaluate medical aspects of exercises using established criteria and/or METs, as appropriate.

2.1.21.9. Provide the medical unit commander and wing commander an exercise outcome report, in accordance with wing directives and timelines.

2.1.21.10. Provide post-exercise feedback to the MR office for inclusion in the Post-Incident/Exercise Summary (PIES). Brief the PIES and exercise results to the MRC/EMC at the next meeting following the exercise. Recommend solutions to exercise findings or discrepancies, as appropriate.

2.1.21.11. Ensure SABC is evaluated during Wing exercises involving injuries and provide feedback to units evaluated.

2.1.22. **MCRP Team Chiefs.** To improve team stability, team chiefs must remain in their positions for a minimum of 12 months. MCRP team chiefs (includes LS MTF, LSISS MTF and ARC unit teams identified to support the wing/installation Comprehensive Emergency Management Plan (CEMP) 10-2 or sister service equivalent) will:

2.1.22.1. Plan for all installation contingency response scenarios, including events with CBRN aspects. Include MC-CBRN procedures and guidance in the team's MCRP annex and develop checklists that address team response to all potential scenarios. **Note**: this applies to all MCRP teams, not only those with assigned MC-CBRN assemblages. Teams with no MC-CBRN assemblages should address how a CBRN event might affect team operations and any procedures that may require modification in response to the presence of CBRN elements.

2.1.22.2. Prepare and maintain the team's MCRP annex and submit it to the MR office for publication in the MCRP.

2.1.22.3. Conduct team training and/or assign trainers, as necessary, to ensure training for all team members. Establish a mechanism to identify individuals who require make-up training, including newly assigned members who have missed previous training events, and ensure make-up training is conducted within 60 days of return to duty. Conduct initial orientation for all newly assigned team members within 30 days of assignment.

2.1.22.3.1. The BE office may assist in verifying trainers are qualified to teach First Responder Awareness Level and First Responder Operations Level Training for Hospital-Based First Receivers (initial and refresher) or in finding training from an outside source.

2.1.22.3.2. First Responder Awareness and Operations training materials are mentioned in paragraph 6.5.1.1 of this Instruction and posted on the AF Medical Readiness CoP. Also, see the Minimum MCRP Team Training Matrix in the AFI 41-106 Toolbox, on the AF Medical Readiness CoP.

2.1.22.4. Maintain an active MRDSS ULTRA account. Document team training for assigned personnel in MRDSS ULTRA or designate a team member to accomplish this task. Ensure training is updated within two duty days of the training event, or by the next Unit Training Assembly (UTA) for ARC units.

2.1.22.5. Ensure team personnel who are required to wear respiratory protection are enrolled in the Installation Respiratory Protection Program and participate in proficiency testing for equipment listed on MC-CBRN allowance standards, as applicable. This includes members of the Manpower Team who may conduct activities or augment other teams in the warm zone, as determined at the unit level.

2.1.22.6. For teams without MC-CBRN assemblages, identify team equipment and supply requirements for inclusion in planning, programming, and budgetary submissions. Assess ongoing equipment and supply levels. Ensure required inventories are completed IAW AFI 41-209, Chapter 11.

2.1.22.7. Team chiefs identified in Table 7.1 are responsible for maintaining their teams' MC-CBRN assemblages (886 AS). These team chiefs will:

2.1.22.7.1. Designate a team property custodian to actively manage the team's AS, in collaboration with medical logistics. Although medical logistics is responsible for maintaining AS data in Defense Medical Logistics Standards Support (DMLSS), team chiefs are ultimately responsible for ensuring the accuracy of their AS data. Property custodian duties are outlined in AFI 41-209, Chapter 1, and AFMAN 23-110, Volume 2, Part 13, Chapter 8. All DMLSS actions related to AS sustainment and inventory management will be accomplished by medical logistics in accordance with policies and procedures outlined in AFI 41-209.

2.1.22.7.2. Conduct an inventory of team equipment and supplies once annually and after use for exercises or real world events, in accordance with AFI 41-209. Medical logistics and/or a contracted logistics inventory team and the team chief and team members will collaboratively perform the inventory functions. AS training for team members and operational testing of equipment will be conducted once annually, in conjunction with an exercise or an inventory. The annual inventory requirement may also be met with a post-exercise inventory as long as all required inventory actions are accomplished.

2.1.22.7.3. Submit annual budget requirements for assemblage resupply and training/exercises to the MR office.

2.1.22.7.4. The Clinical Services or Immediate Team Chief (see paragraph 7.2.8) is responsible for the management of assemblage SG05, Pandemic Influenza Supplies and Equipment. The Pharmacy Team Chief (886E) is responsible for the management of assemblage SG06, Pandemic Influenza Pharmaceuticals. Reference MRDSS ULTRA, Capability Overview, HLD/Customer Owned Assemblages for specific information on these assets.

2.1.22.8. Establish a mechanism to recall team members in response to an incident, and exercise it at least annually.

2.1.22.9. Brief the status of team capabilities to the MRC/EMC. Included in this update should be the status of team manning, training, equipment and supplies, exercise requirements, and an overall assessment of the team's readiness to respond. Also brief inventory results, get well plan, and assessed capability. Specific briefing requirements are discussed in paragraph 4.3.2.3.

2.1.23. **UTC Team Chiefs or UTC Family Group Leaders**. At their discretion and considering the size of assigned UTCs, commanders will appoint team chiefs and alternates for each assigned UTC or a UTC family group leader and alternate for each group of UTCs. UTC family groups may be comprised of multiple copies of the same UTC, as might be the case at a CDM site, or complimentary UTCs (i.e., FFPM1, FFPM2, FFMP3, etc) based on unit necessity. UTCs identified for sustainment missions do not require the appointment of UTC team chiefs or UTC family group leaders. A list of sustainment UTCs is located on the AF Medical Readiness CoP. Maintenance of hard copy UTC team chief/UTC family group leader binders is optional for UTCs with no MRA identified local training requirements. UTC team chiefs or UTC family group leaders will:

2.1.23.1. Ensure assigned UTC personnel are scheduled for and accomplish required training.

2.1.23.2. Brief UTC members on relevant UTC CONOPS, MEFPAK playbooks, and MISCAPs annually.

2.1.23.3. Maintain UTC personnel rosters and recall capability (electronic or hard-copy) for UTC members.

2.1.23.4. Operationally test assigned WRM UTC equipment annually. Operational testing will involve team members and is defined as full set-up, turning equipment on, validating that all the necessary pieces are available and in working condition, and re-packing the assemblage for potential future operational use.

2.1.23.5. When the base is host to ARC or other Active Duty units with similar personnel UTCs, ensure the tenant or supporting units are given the opportunity to train with the host unit's equipment UTCs if available; however, the host units have ultimate responsibility for operationally testing their own equipment.

2.1.24. **Unit AFSC Functional Training Managers.** AFSC functional training managers at the unit level include enlisted functional managers and the senior officer from each corps (excluding the unit commander). For clinical Biomedical Sciences Corps (BSCs), RSVP oversight will be provided by the SGH (or equivalent), or the SGP for ARC units. These individuals will:

2.1.24.1. Review RSVP checklists to identify training tasks. Conduct or oversee RSVP training, as appropriate. Conduct make-up training within 60 days (two UTAs for ARC units) for individuals who miss scheduled training events.

2.1.24.2. Perform a gap analysis annually, or each time the RSVP checklist is updated. Determine which training is satisfied during daily practice, as part of upgrade training, or can otherwise be accomplished at the unit. Identify in the gap analysis training that may be accomplished through local training affiliations or special training events ("local"

training) and training that cannot be accomplished locally and requires AF level consultant or CFM assistance ("non-local" training).

2.1.24.2.1. Determine an appropriate methodology and timeline for completing RSVP task training that requires special training events. Develop strategies, to include local TAAs or temporary duty (TDY) for training to fulfill RSVP "local" training tasks. RSVP "local" training gapped tasks must be completed within the task timelines established on the RSVP checklist, typically 24 months.

2.1.24.2.2. If unable to identify workable options through local resources, elevate RSVP gaps to the appropriate AFSC consultant or CFM for action, with a courtesy copy to the parent MAJCOM/SGX. Include the date of submission and the name of the AFSC consultant or CFM in the gap analysis documentation. RSVP "non-local" training tasks must be completed within 48 months of submission to the consultant or CFM, as they are likely to require additional funds, TDYs, or special training events. Work closely with the unit resource management office (RMO) and the MRO to submit funding requirements. **All RSVP training must be complete and proficiency verified prior to deployment.**

2.1.24.2.3. When RSVP checklists are updated or changed, follow implementation guidance provided by the consultant or CFM. If no implementation guidance is provided, training for new tasks must be completed within six months of publication of the new RSVP checklist.

2.1.24.2.3.1. Review the new RSVP checklist and determine an implementation plan, including methodologies for accomplishing new training tasks within the established timeline.

2.1.24.2.3.2. Brief the MRC on the scope of RSVP checklist changes and resulting implementation plan, including at a minimum, the number of new tasks, the previous RSVP percentage, and the new percentage, and an estimated completion date.

2.1.24.3. Maintain an AFSC Functional Training Manager binder containing the following: a copy of the appointment letter; pertinent RSVP lesson plans; sign-in rosters including dates of training, subjects covered, attendees, and instructor signature; reference materials; a copy of the most recent gap analysis; and a copy of the RSVP checklist change implementation plan and consultant/CFM implementation guidance, if applicable. For LS and LSISS MTFs only, the binder may be consolidated and maintained in the MR office; the MR office may also assist with updating RSVP training data in MRDSS ULTRA.

2.1.24.4. Conduct RSVP proficiency verification for personnel tasked to deploy within 90-120 days of their projected departure date, or as soon as possible after deployment notification if less than 90 days. Successful completion of C-STARS within twelve months prior to deployment satisfies the requirement for RSVP proficiency validation. Conduct additional training as required to ensure task competency prior to deployment. For tasks that are beyond the unit's capabilities (RSVP gap items), perform a thorough review of associated procedures with the deploying individuals. Document the RSVP proficiency validation in MRDSS ULTRA.

2.1.24.5. Download and print an RSVP checklist from MRDSS ULTRA for personnel tasked to deploy. Deploying individuals will track tasks performed during deployment and obtain the deployed MTF commander's signature to request RSVP credit upon return to homestation. See paragraph 6.7.2 for additional guidance.

2.1.24.6. Validate RSVP training that is accomplished during deployments or exercises and present training credit recommendations to the unit commander or his designated approval authority. For training accomplished during deployments or exercises, utilize the deployment return or exercise termination date as the training completion date.

2.1.24.7. Brief the status of RSVP training and the gap analysis to the MRC/EMC at the discretion of the commander. Additionally, at least annually, address RSVP training gap analysis and proposed solutions, identifying which items may require AFMOA consultant or CFM assistance.

2.1.24.8. Obtain an MRDSS ULTRA account from the MRDSS ULTRA Unit System Administrator. Maintain documentation on all AFSC-specific RSVP training in MRDSS ULTRA. Document currency by updating training data in MRDSS ULTRA within two duty days of training completion or as soon as possible, as mission allows. For ARC units, RSVP training will be updated by the end of the following unit training assembly (UTA). **Note:** For LS and LSISS MTFs, a single individual may be designated to enter all RSVP training data. However, functional training managers are still responsible for other requirements listed in paragraph 2.1.23.

2.1.24.9. Review personnel on-the-job training (OJT) records and IDMT folders, if applicable, prior to each deployment to validate that all required training has been completed and properly documented.

2.1.25. **First level supervisors.** Defined as immediate supervisors, these individuals will:

2.1.25.1. Ensure personnel and office activities fully support all medical readiness requirements.

2.1.25.2. Ensure subordinates' ongoing competence in individual skills required by their UTC and MCRP team assignments and/or AFSC. Provide training to correct deficiencies.

2.1.26. **AF Medical Personnel.** All AFMS personnel and non-medical personnel assigned to medical units will:

2.1.26.1. Maintain an awareness of their UTC and AEF Tempo Band Block assignment.

2.1.26.1.1. Complete all medical readiness training required for deployment.

2.1.26.1.2. Maintain individual readiness and meet personal deployment requirements. Notify the MR office immediately of any deployment limiting conditions or availability issues.

2.1.26.1.3. Adopt and maintain a "mission-ready" attitude.

2.2. Additional Roles and Responsibilities. This chapter captures most roles and responsibilities associated with the medical readiness programs addressed in this Instruction. However, additional responsibilities not mentioned here may be levied by other publications or directives.

Chapter 3

MEDICAL READINESS PROGRAM MANAGEMENT

3.1. The Medical Readiness Office. The MR office is the hub of readiness activities at the unit level. Personnel assigned to this office manage programs spanning the full range of global medical operations activities. To meet program requirements, there must be a minimum of two full-time personnel assigned to the MR office. Two primary positions in the MR office are the Medical Readiness Officer (MRO) and the Medical Readiness NCO (MRNCO). Depending on the size of the facility and the medical readiness program, the MRO may be appointed on a part-time basis. In this instance, a second enlisted member must be assigned to meet the two-person minimum staffing requirement. Whether full or part-time, the MRO must have sufficient time and resources to perform required MRO functions. A DOD civilian Medical Readiness Manager (MRM) may fill either the MRO or MRNCO position in a full-time capacity. For ARC, full-time refers to traditional reservists filling the MRO or MRNCO roles. See paragraph 2.1.17 for additional roles and responsibilities. LS, LSISS, and deployed MTFs are exempt from the two-person minimum staffing requirement.

3.1.1. **Tenure**. The MRO, MRNCO and MRM will serve in their positions for a minimum of 24 months, unless PCS'd.

3.1.2. **Core Competency.** Medical readiness is a core competency for the 041AX officers and the 4A0X1 enlisted personnel. Therefore, 041AX medical service corps officers and 4A0X1 healthcare managers should be the primary AFSCs assigned to the Medical Readiness Office. Other individuals may be added to the medical readiness staff as appropriate. For AFRC units only, when 041AX and/or 4A0X1 personnel are not assigned, personnel with any medical AFSC may serve as the Medical Readiness Officer or NCO. Every effort should be made to avoid assigning additional duties, such as security manager, building custodian, etc., to the MR office staff.

3.1.3. **Training.** Newly assigned MROs/MRNCOs/MRMs will attend and successfully complete J3OZR4XXX-00BD, Medical Readiness Management Course (MRMC) before or within six months of assignment to MRO/MRNCO/MRM duties. ARC members will attend within 12 months. The MRMC staff will identify areas not successfully completed to the individuals' home units for additional training and supervision until competency is achieved.

3.1.3.1. Newly assigned MRO/MRNCO/MRMs will also complete their position-specific and UDM training modules in MRDSS ULTRA, provided on the MRDSS training server, within 90 days of assignment. Upon completion of the modules print the MRDSS Training Course List page, update the appropriate completion dates in MRDSS ULTRA, and file the hardcopy in the individual's medical readiness training record. Access to the training server can be obtained through the MRDSS help desk at the number or via the link provided on the MRDSS ULTRA logon page.

3.1.3.2. Upon completion of all required training and a year of serving in the MRNCO position, enlisted members should be awarded the 325 Special Experience Identifier (SEI).

3.2. MR Roles Appointed in Writing. MRO/MRNCO/MRM responsibilities are discussed in 2.1.17 and outlined in this chapter.

3.2.1. **Unit Deployment Manager (UDM).** UDMs have primary responsibility for matching personnel to UTC positions and ensuring those personnel are trained and equipped to accomplish the missions of the UTCs to which they are assigned. Specific duties include:

3.2.1.1. Identify personnel to fill UTC positions, in coordination with the unit AFSC functional manager, using the Control AFSC (CAFSC) for enlisted personnel and Duty AFSC (DAFSC) for officers. Ensure the best AFSC and grade skill level match in accordance with AFI 10-403, the UTC Mission Capability Statements (MISCAPs) and other applicable supplemental processing guidance or reporting instructions.

3.2.1.1.1. Review Duty Status reports from the Commander's Support Staff (CSS) prior to assigning personnel to UTC positions. Update MRDSS ULTRA with any duty status changes. Before selecting individuals to deploy, UDMs and unit commanders must verify individual duty status and deployment availability (DAV) codes to verify that the individual is present for duty or can be recalled from TDY, and that there are no discriminating legal, security, medical, or administrative factors that may render a member ineligible to deploy.

3.2.1.1.2. Assign personnel to UTCs using MRDSS ULTRA and update deployment preparedness information.

3.2.1.1.3. Conduct a UTC orientation for personnel upon appointment to the UTC. The orientation will include a review of the following, as a minimum:

3.2.1.1.3.1. The current UTC team roster with contact information.

3.2.1.1.3.2. The current MCRP Annex S, *Deployments*.

3.2.1.1.3.3. Pertinent portions of the installation deployment plan (IDP).

3.2.1.1.3.4. The UTC manpower force element listing (MFEL) for the UTC, and applicable TTPs.

3.2.1.1.3.5. The Air Force-Joint Lessons Learned Information System (AF-JLLIS) Quick Reference Guide, available on the AF Medical Readiness CoP.

3.2.1.1.3.6. Provide copies of the above documents, as appropriate.

3.2.1.2. Coordinate and manage medical deployment activities, to include deployers and deployment processing support activities.

3.2.1.2.1. Upon notification of a potential deployment, enter tasked members' anticipated deployment date and estimated tour length in MRDSS ULTRA. Update the data as necessary if the individual ultimately deploys on a different date or does not deploy.

3.2.1.2.2. Meet with deploying personnel or teams and review all tasking line remarks and reporting instructions. Have deploying personnel complete DD Form 2795, *Pre-Deployment Health Assessment*, in the Aeromedical Services Information Management System (ASIMS) to ensure any medical conditions which might preclude deployment are identified immediately. DD Form 2795 may be submitted as paper copy, if locally directed. Review the pre-deployment checklist.

3.2.1.2.3. Coordinate with the Installation Deployment Officer (IDO), Individual Personnel Readiness (IPR) unit, and Unit Medical Readiness Training Manager to schedule personnel to complete required training. Ensure sufficient training is scheduled such that all required initial, sustainment, and recurring training remains current for the duration of the deployment.

3.2.1.2.4. Print out AF IMT 4005, *Individual Deployment Requirements*, and AF Form 1098, *Special Task Certification and Recurring Training*, from MRDSS ULTRA and prepare AF Deployment Folders (AFDF) in accordance with AFI 10-403 and the Installation Deployment Plan (IDP).

3.2.1.2.5. Coordinate personnel predeployment processing activities, to include processing lines, notification of AFSC Functional Training Managers to ensure training certification, AFDF reviews, personal deployment bag inventories, immunization reviews, country clearance requests, and passport verification.

3.2.1.2.6. For units with assigned WRM UTCs, maintain coordination with the Medical Logistics Office to ascertain its deployability and availability of necessary biological and chemical warfare antidotes. Ensure WRM UTC deployment requirements and timelines are met in accordance with the IDP.

3.2.1.3. For units deploying a complete UTC or set of UTCs, consider pre-building an AAR in AF-JLLIS. This will facilitate input of issues from the AOR and expedite AAR completion post-deployment. See paragraph 9.3.1.2 for additional information on AF-JLLIS.

3.2.1.4. Conduct Post-deployment Activities. Individuals will report to the UDM upon return from deployment and provide documentation of training accomplished during the deployment. The UDM will:

3.2.1.4.1. Update MRDSS ULTRA to reflect that the individual has returned from deployment. Notify the appropriate MCRP team chief of the need to assess for make-up training. MCRP team chiefs will ensure make-up training is conducted within 60 days of return from deployment, if required.

3.2.1.4.2. Forward requests for RSVP deployment training credit to appropriate AFSC functional training manager for review and recommendations.

3.2.1.5. At any time during deployment activities, refer UTC-specific questions to the appropriate MRA through the parent MAJCOM, if required.

3.2.2. **Unit Plans Officer/NCO.** Unit level planners assess the medical unit's capabilities to support expeditionary and installation response requirements. See Chapter 5 for specific planning responsibilities, including coordination of emergency management and contingency MOUs/MOAs/MAAs. Response capabilities and procedures are developed and implemented through publication of the MCRP and input to wing plans. Plans utilized and supported include but are not limited to:

3.2.2.1. MCRP. The MCRP details responsibilities and actions required to accomplish the unit's contingency response mission. See paragraph 5.5 of this Instruction for further details regarding the MCRP.

3.2.2.2. Comprehensive Emergency Management Plan (CEMP) 10-2. The Installation CEMP 10-2 is a base-level plan that aligns AF planning with the National Response Framework. Details are provided in AFI 10-2501.

3.2.2.3. Disease Containment Plan (DCP). The DCP addresses roles and procedures for responding to a disease outbreak. Details are provided in AFI 10-2604, *Disease Containment Planning Guidance.*

3.2.2.4. Installation Deployment Plan (IDP). The IDP provides details for deployment processing, tailored to a particular installation. AF-level guidance is provided in AFI 10-403.

3.2.3. **Unit Reports Monitor.** The Unit Reports Monitor is responsible for preparing the unit's operational readiness reports, including SORTS, DRRS, and ART; collecting unit mission preparedness data; and providing the information to the unit commander for assessment and approval. MRDSS ULTRA is the source system for readiness reporting. Specific reporting requirements are detailed in Chapter 9 of this Instruction.

3.2.4. **Unit Medical Readiness Training Manager.** The Unit Medical Readiness Training Manager coordinates, schedules, tracks and documents medical readiness training. Reference Chapter 6 and Attachment 3 of this Instruction for detailed training information. Duties include, but are not limited to:

3.2.4.1. Serve as an informational resource for AFSC Functional Training Managers managing the Readiness Skills Verification Program (RSVP).

3.2.4.2. Assist the MRO and MRNCO in preparing the MRTES.

3.2.4.3. Plan and oversee the implementation of unit medical readiness training events.

3.2.4.4. For UTCs that do not have UTC-specific courses, ensure members review their UTC TTP, MISCAPS, METLs, and allowance standards every 24 months.

3.2.4.5. Ensure all medical readiness and deployment training is documented in MRDSS ULTRA for:

3.2.4.5.1. Assigned unit personnel, ensuring personnel deploying as substitutes outside their assigned UTCs receive required training for newly tasked UTC.

3.2.4.5.2. IMAs that are attached to the unit. Assign IMAs to the FFAZZ Associate UTC in MRDSS ULTRA for tracking purposes. They will not count against unit training statistics.

3.2.4.5.3. Other medical personnel on base who may not work within the medical facility (e.g. Squadron Medical Element (SME) personnel). These individuals can be tracked by associating their unit PASCODE with the MTF within MRDSS ULTRA and will not affect MTF training statistics. Contact the help desk for assistance with this process. If coordination of training events or dates with these units is not successful, document associated communications in a memorandum for record. **EXCEPTION:** AFSOC Operational Support Medical (OSM) flights track their own training in MRDSS ULTRA.

3.2.5. **MRDSS ULTRA Unit System Administrator.** The unit MRDSS ULTRA Unit System Administrator will create user accounts, review and drop/delete unit-level user accounts no longer requiring access, and ensure positive control of sensitive information contained within the system. In addition, the System Administrator will:

3.2.5.1. Maintain MR office accounts. Recommend issuing each member of the MR Office staff an individual account.

3.2.5.2. Create and maintain Education and Training (E&T) office accounts. Larger facilities may designate a second MRDSS ULTRA Unit System Administrator in the E&T office to specifically manage E&T accounts. The MRDSS ULTRA Unit System Administrator will provide AFSC functional training managers, MCRP team chiefs, and GME directors MRDSS ULTRA accounts to enter training data for their personnel.

3.2.5.3. Provide assistance to unit users as necessary. Contact the parent MAJCOM MRDSS ULTRA representative for assistance or guidance. The MRDSS ULTRA Unit System Administrator will contact the Help Desk only if the MAJCOM representative is unable to provide assistance.

3.2.5.4. Provide recommendations for updates or changes to MRDSS ULTRA to the parent MAJCOM for consideration by the Configuration Control Board (CCB)

3.2.6. **Provide Oversight to the MC-CBRN Program.**

3.2.6.1. Manage the utilization of MC-CBRN program funds in conjunction with the resource management office and in accordance with guidance in AFI 41-120. Fiscal information is provided on the AF Medical Readiness CoP; equipment and supplies will be funded first, with MAJCOM/SGXs prioritizing other requirements which may be funded IAW this guidance.

3.2.6.1.1. Unit MR Offices will send an annual POM submission to their MAJCOM/SGX in accordance with published programming guidance and in coordination with the unit RMO.

3.2.6.1.2. AS items used during MC-CBRN training or exercises will be replenished using PE 28036F (MC-CBRN) LAF funds (PE 58036F for ANG). Items used for other medical unit generated training or exercises without specific MC-CBRN components, will be replenished using medical operations and maintenance (O&M) funds. Items used for wing generated exercises should be replenished with wing LAF funds.

3.2.6.2. The MRO will chair the MC-CBRN Working Group. The MC-CBRN Working Group will be comprised of medical logistics, medical EET Chief, MR staff (as appropriate) and the team chiefs listed in table 7.1, as a minimum and will meet prior to each MRC meeting. The MRO will provide an MC-CBRN Working Group update to the MRC/EMC as a standard agenda item at every meeting, as described in paragraph 4.3.2.4 and 9.2.3 of this Instruction.

3.2.6.2.1. The MC-CBRN Working Group will address the following unit MC-CBRN program areas, at a minimum: overall program funding status and execution update, equipment issues and inventory schedule, personnel status (shortfalls and training), the status of MOUs/MOAs/MAAs, exercise requirements status and PIES open items at each meeting. The working group will determine individual team and overall unit MC-CBRN readiness status, identify risks associated with degraded capability and determine corrective actions. Readiness status, risk, and corrective actions will be included in the MC-CBRN Working Group update to the MRC. Specific factors to consider in determining team and unit readiness are listed in table 3.1.

Table 3.1. MC-CBRN Readiness Factors.

Factor	Criteria
Equipment Status	Assess the risk associated with any AS bundle below 100% and determine corrective actions. Assess the risk associated with missing non-critical items and determine corrective actions to mitigate the risk.
Training Status	The training requirements for each team are listed in chapter 7. Assess the risk associated with team training below 100% trained, and determine corrective actions to accomplish required training.
Team Performance	Assess observed performance of mission essential tasks for each team, as documented in PIES for exercises and real world events, and assess the risk associated with performance that does not meet operational standards. Where operational standards are not published, performance must conform to local concepts of operation and plans.
Force Availability	Assess the risk associated with forecasted PCSs, deployments or other situations that affect the availability of key team personnel. Where risk is unacceptable determine a succession plan or a stop-gap plan for the period a team is below required strength.

3.2.6.3. Units that maintain MC-CBRN assets (886 allowance standards (AS) for active duty units and 976 AS for ANG) will report MC-CBRN/HSMR as a generation mission in MRDSS ULTRA. Include military members, civilians, and contractors assigned to MCRP teams in the required, assigned and available numbers.

3.2.6.4. MTFs assigned MC-CBRN assemblages are not authorized to decrease AS levels but may enhance local capabilities based on threat assessments, medical capabilities and limiting factors. Increases to AS levels must be approved by the MRC/EMC and documented in the minutes. Approved increases will be forwarded to the parent MAJCOM/SG for final approval. **EXCEPTION:** If assigned, LS and LSISS MTFs may modify 886 AS to provide appropriate capability with AFMSA/SGXH approval (see Attachment 5).

3.2.7. **Medical Readiness Program Management Functions.** The following functions are also managed by the MR office:

3.2.7.1. **Readiness In- and Out-processing**. Conduct medical readiness in-processing and out-processing for assigned personnel.

3.2.7.1.1. Establish standardized in-processing procedures for all newly assigned personnel. Develop an orientation checklist to include: in-processing in MRDSS ULTRA; AFMS and Unit Mission Briefing; MCRP review; UTC assignment and deployment requirements; MCRP team assignment; training requirements; names and duty sections of team chiefs; and current training status.

3.2.7.1.2. Establish standardized out-processing procedures for personnel permanently changing station, separating or retiring, including out-processing in MRDSS ULTRA. Print out training data if necessary and provide the individual's AFDF.

3.2.7.2. Provide oversight and support to MCRP Team Chiefs.

3.2.7.2.1. Register MCRP team chiefs and assign team members using MRDSS ULTRA.

3.2.7.2.2. Ensure team chiefs know their responsibilities, which include, but are not limited to: maintaining contact information for their team members; developing and maintaining team training lesson plans; ensuring their team members are trained and the training is documented in MRDSS ULTRA; obtaining, maintaining and inventorying team supplies and/or equipment; reviewing and updating the team's annex in the MCRP as well as supporting operational checklists. Include in all management activities MC-CBRN responsibilities and assets in accordance with AFI 41-209, and this Instruction. Establish a standard for MCRP team chief binders. Include the following, as a minimum:

3.2.7.2.2.1. Team chief and alternate appointment letters, current team recall roster.

3.2.7.2.2.2. A printed copy of the team's MCRP annex. The MCRP itself may be maintained electronically as long as a cross-reference sheet identifying its exact location is included in the team chief binder.

3.2.7.2.2.3. Copies of the team's MCRP supporting checklist(s).

3.2.7.2.2.4. Team equipment and supply lists and documentation of inventories. For teams with assigned MC-CBRN assemblages, this information is maintained electronically in DMLSS and is viewable in MRDSS ULTRA.

3.2.7.2.2.5. Team-unique lesson plans and training sign-in rosters (minimum of two years).

3.2.7.2.2.6. A copy of the unit's MRTES, or a cross-reference sheet if maintained electronically.

3.2.7.2.2.7. Exercise feedback forms, if used.

3.2.8. **Coordinate with the Medical Exercise Evaluation Team (EET) Chief.** Provide exercise requirements to assist with exercise scenario development to ensure medical capabilities are adequately tested. Coordinate the development of the MRTES with the Medical EET representative to facilitate the integration of medical exercise requirements with planned wing exercises to the greatest extent possible. Assist the medical EET representative in incorporating DRRS METs into exercise objectives and evaluation criteria, ensuring all applicable METs are tested at least annually. Assist in the scheduling of Terrorist Use of CBRNE Exercises to coincide with the annual contractor supported MC-CBRN AS inventory, streamlining inventory processes to the greatest extent possible.

3.2.9. **Manage Deployment Weapons and Munitions.** Weapons authorizations for medical UTCs are provided on the AF Medical Readiness CoP. Munitions authorizations for internal security, protection, and personal defense are found in AFCAT 21-209, *Ground Munitions*. Medical unit munitions may be consolidated with other wing units; however, the MR office must confirm with the IDO that their deployed munitions requirements are met.

3.2.10. Establish the Medical Control Center (MCC)/Unit Control Center (UCC).

3.2.10.1. Establish the MCC/UCC, ensuring sufficient space, equipment, and checklists/plans. Provide access to classified materials, if required.

3.2.10.2. In accordance with local communications squadron guidance, ensure the MCC/UCC equipment items include telephones, at least one secure terminal equipment (STE), computer systems (secure/non-secure), and land mobile radios (LMRs). All authorized communications items should be physically in the MCC/UCC when feasible. **Note:** LMRs may be used for daily operations but must be identified for MCC use when needed.

3.2.10.3. Provide MCC/UCC manpower, either as team members or augmentees, as specified by the unit MCRP. Monitor and operate the MCC/UCC until activation of the MCC Team.

3.2.11. **Prepare and Maintain the Medical Readiness Training and Exercise Schedule (MRTES).** The MRTES is the primary tool for scheduling unit medical readiness training and exercises. MR office personnel have the responsibility to incorporate training events, courses, and exercises into a schedule that meets the training needs of all assigned personnel, while considering the unit's business plan and resource availability. Deployed MTFs are not required to develop a MRTES.

3.2.11.1. There is no prescribed format for the MRTES, however a recommended template is provided on the AF Medical Readiness CoP in the AFI 41-106 Toolbox. Units will develop a flexible training schedule that incorporates all readiness training requirements listed in Chapter 6 and Attachment 3 of this Instruction, as well as training required by other AFIs. Include a comprehensive listing of all planned exercises (see Attachment 6) for a period of 24 months. Include appropriate make-up training timelines.

3.2.11.2. For RSVP training, project a training timeline for each assigned AFSC. For example, 4N0 RSVP training might be listed as occurring from 1200-1300 on the second and fourth Tuesdays of each month, or a specified time during a Unit Training Assembly (UTA) for ARC units.

3.2.11.3. List all planned exercises that require individual or unit participation. Use the wing/base exercise schedule as a starting point to capitalize on available exercise opportunities and avoid conflicts in planning.

3.2.11.4. The MRC/EMC will review and approve the MRTES annually prior to the beginning of the next calendar year and any time there is a change to the composite schedule.

3.2.11.5. Once approved, distribute copies to the impacted organizations and team chiefs and post the MRTES on a shared drive or other location that is easily accessible by unit personnel.

3.2.12. **Maintain MR Office Documentation.** Maintain a copy of all unit readiness-related appointment letters and validate their currency quarterly. MCRP, MRC/EMC minutes including supporting documentation, appointment letters, training data, and the MRTES can be maintained electronically without hard copy print-outs as long as all interested parties can access them. At the unit commander's discretion, properly formatted electronic signatures may be utilized on appointment letters. Back-ups of all documentation must be made at least monthly (see paragraph 3.3.5.), and legitimate requests for hard copies will be honored. ANG units may use the Self Inspection Database (SID) to store documents.

3.2.13. **Conduct MR Office Self-inspection.** Integrate the MR elements of the AFIA/SG Health Services Inspection (HSI) Guide into the unit self-inspection program. Maintain an active self-inspection program with the goal of continuous improvement and compliance. Brief the status of the MR self-inspection to the MRC/EMC as required.

3.2.14. **Support Readiness-related Business Planning**.

3.2.14.1. MTF commanders are expected to execute a business plan that maximizes the use of assigned personnel and available resources, optimizing facility capabilities. This strategy allows a commander to plan and execute effective training at a predictable cost in terms of both resources and MTF production. The MR office will provide input for the development of the readiness business plan. Readiness business planning is accomplished by considering all types of required resources, to include: manpower; funding for training and travel; contracted services; supplies and equipment (to include maintenance); patient care hours designated for readiness training and exercises; and actual pre-deployment and deployment hours required for global expeditionary operations. Local real-world support activities for emergency management and home station medical response should also be included. (Not applicable to ARC units)

3.2.14.2. The MR office, in consultation with the MRC/EMC, ensures MR training and exercise requirements are considered and incorporated into productivity estimates for each year.

3.2.14.3. As part of the parent MAJCOM POM process, the MR office through the MRC/EMC submits to the resource management office (RMO) the manpower and funding requirements needed to fulfill the unit's deployment and installation medical response missions, exercises, and training. Additionally, all Authorization Change Requests (ACR) will be coordinated with the MR office as any change may affect the unit's readiness taskings.

3.3. Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS ULTRA). MRDSS ULTRA provides enhanced global visibility of medical materiel, personnel, and their training to allow for the efficient management and deployment of those assets. MRDSS ULTRA is the official system of record for the management of expeditionary medical personnel and resources for the AFMS and the single authoritative source of readiness training data for medical personnel and UTC apportionment through the MRL. The governing directive for MRDSS ULTRA is this Instruction.

3.3.1. **Access.** Only authorized medical personnel and units, and others requiring access for official use, are granted access to MRDSS ULTRA. The data it contains will not be released nor provided outside the AFMS or supporting agencies without prior approval by appropriate level command authorities.

3.3.1.1. The MRO/MRNCO/MRM and MRDSS ULTRA Unit System Administrator will contact the MAJCOM SGX POC to obtain an account, as well as MAJCOM-specific usage guidance. Other unit personnel, including E&T personnel and all MCRP team chiefs will contact the MRDSS ULTRA Unit System Administrator to obtain accounts. **Note:** The MRDSS Help Desk does not establish user accounts without authorization from MAJCOM or higher headquarters.

3.3.2. **Classification.** The data contained within MRDSS ULTRA is for official use only (FOUO). Although it contains the raw statistical data used to compile classified operational readiness reports, it does not contain, report, collect, or display all the data elements for a UTC, nor does it include supporting remarks or allow for unit commander assessments of the ability of a UTC or MCRP team to perform its specific mission.

3.3.3. **Medical Resource Letter (MRL).** The MRL, maintained within MRDSS, is the tool designed to manage AFMS readiness resources. Information provided in the MRL for a specific unit includes, but is not limited to: UTCs currently apportioned to the unit; UTCs the unit is projected to gain or lose over the next five years; whether assigned UTCs are manpower or equipment; AEF assignments (past, present and projected) for each UTC; UTC availability codes; and additional information for equipment UTCs. In addition, the MRL is utilized to manage the apportionment/distribution of MC-CBRN assemblages (886 AS), using pseudo UTCs HSMRA through HSMRP.

3.3.4. **Data Currency**. The MR office will ensure the currency of MRDSS ULTRA data at all times and update it as events or changes occur. Updates include the following, at a minimum: annotating training events, UTC assignments, MCRP team assignments, DAV codes, unit information such as contact information for medical readiness and medical logistics staff (phone numbers, e-mail addresses, STE numbers, and 24-hour contacts).

3.3.5. **Data Back-up.** Save back-up copies of MRDSS ULTRA data in the form of reports every 30 days, at a minimum. Suggested back-up reports include: **Reportable Statistics** – each report applicable to the unit; **Personnel** – Unit Roster by Alpha; **Personnel** – AFSC Substitutions Report; **Personnel** – Appointed Positions; **Personnel** – Expired DAV Codes; **RSVP** – RSVP Unit Summary; **RSVP** – RSVP Roster - Individual Summary; **Training** – MCRP Team Unit Personnel Training Detail by Team; **Training** – Medical Readiness Training Completion by Category (for applicable categories); **Training** – Training Accomplished by Training Event.

3.4. Pilot Unit Liaison. At MTFs with pilot unit responsibilities, the MR office will maintain program management oversight and act as liaison to the MRA.

Chapter 4

THE MEDICAL READINESS COMMITTEE (MRC)

4.1. Purpose. The purpose of the MRC is to provide executive oversight for all medical readiness activities, to include the organizing, training, and equipping of all assigned personnel, and to ensure the unit is able to meet its assigned expeditionary and installation response missions.

4.2. Duration and Frequency. MRC meeting duration must be sufficient to address all required agenda items. Meetings are chaired by and minutes approved by the unit commander, and will be held every other month, at a minimum. Exceptions are described below:

4.2.1. **Air Reserve Component (ARC).** AFRC MRC responsibilities are fulfilled through the EMC at least quarterly. ANG MRC responsibilities are fulfilled either through the EMC, Education & Training Committee (E&TC), or a combination of EMC and E&TC; meetings are held quarterly. For the purposes of this Instruction, MRC will refer to any committee charged with this function, unless specifically noted.

4.2.2. **Limited Scope (LS) and Limited Scope with Inter-Service Support (LSISS) MTFs.** LS MTFs and LSISS MTFs may incorporate the MRC into the EMC, as appropriate. If incorporated into the EMC, a separate section of the minutes must be dedicated to medical readiness activities and include the standard agenda items identified in paragraph 4.3.2.

4.2.3. **Deployed MTFs**. Deployed MTFs are not required to establish an MRC. However, commanders may consider doing so in order to provide continuity from one AEF rotation to another. If established, use the standard agenda items as a guide and document meeting results in continuity books/binders.

4.3. Meeting Organization. In consultation with the unit commander, the MR office will schedule MRC meetings; develop the agenda and provide it to the members in advance; ensure MCRP team chiefs and AFSC Functional Training Managers, and others as appointed by Commander, are prepared to provide data, briefings, or updates as requested; and prepare MRC meeting minutes following the meeting, using the format provided in attachment 4.

4.3.1. **Membership.** The following individuals comprise the minimum required membership for the MRC and should be identified in the minutes by their MRC title(s):

4.3.1.1. Unit Commander (chairperson).

4.3.1.2. MRO, MRNCO, MRM

4.3.1.3. Executive management team, including functional advisors (SGA, SGD, SGN, SGP, etc.), squadron commanders, and unit superintendents.

4.3.1.4. Bioenvironmental Engineer (BEE).

4.3.1.5. Public Health Emergency Officer (PHEO)/ANG PHEO Liaison.

4.3.1.6. Public Health Officer (PHO).

4.3.1.7. Medical Logistics Officer.

4.3.1.8. Medical EET Chief.

4.3.1.9. Education and Training Officer (or representative).

4.3.1.10. Reserve Affairs Liaison, when appointed.

4.3.1.11. Other individuals as directed by the chairperson, including RMO, UDM, AFSC functional training managers, etc.

4.3.2. **Agenda.** MRC meetings will include approval of past minutes, discussion of any open items, standard agenda items prescribed below, and new business. The MRC will address the following standard agenda items, at a minimum:

4.3.2.1. Unit Plans Review. Provide status of required plan reviews, including the MCRP, wing/base plans, and applicable emergency management and contingency MOUs/MOAs/MAAs.

4.3.2.2. Medical Readiness Training Update. The comprehensive training update should include training statistics briefed by designated POCs. Include training provided for attached ARC personnel, in accordance with paragraph 10.4.2.3.4, and other medical personnel assigned to the base that do not work within the MTF.

4.3.2.3. MCRP Team Chief Update. MCRP team chiefs will brief, at a minimum, team staffing and overall team training status to include make-up training. At the commander's discretion, team chiefs may provide updates on a rotating basis, as long as all team chiefs report at least once during the year. Exceptions to the rotation are described in paragraphs 4.3.2.4.1 and 4.3.2.4.2 below.

4.3.2.4. MC-CBRN Program Update. The MRO will provide an MC-CBRN Working Group update at every MRC meeting in accordance with paragraphs 2.1.17.9.2 and 3.2.6.2 of this Instruction. The MRC will evaluate the risks and recommendations, identify appropriate OPRs, actions, and advise the MRO on MC-CBRN readiness information to be presented to the installation Emergency Management Working Group (EMWG) and Installation Readiness Council (IRC) (frequency determined locally) to enable an integrated installation response capabilities assessment. In addition, MCRP team chiefs listed in Table 7.1 of this Instruction will:

4.3.2.4.1. Provide team-specific personnel and training status updates at every MRC meeting when team percentages are less than 85%. The briefing must reflect proactive management, addressing specific actions being taken and anticipated get-well dates, and be documented in the MRC minutes.

4.3.2.4.2. Brief the status of their assemblages at every MRC meeting, until their assemblages are fully mission capable as defined by meeting threshold levels for all bundled critical items. Updates thereafter can be provided by exception, when there are issues to discuss. Team chief updates will address materiel status, critical item shortages, open items/lessons learned from the most recent inventory, get well plan, reportable percentage (RP), team capability overview, and projected get-well dates, at a minimum.

4.3.2.5. UTC Team Chief/UTC Family Group Leader Update. Team chiefs and/or family group leaders will brief, at a minimum, team staffing and overall team training status to include make-up training. In addition, team chiefs at pilot units will provide an update on any ongoing pilot unit activities associated with their UTCs. At the commander's

discretion, team chiefs/family group leaders may provide personnel and training updates on a rotating basis, as long as all team chiefs provide an update at least once during the year.

4.3.2.6. Exercise Update. The medical EET chief will present all new PIES and base exercise reports, to include exercise findings, discrepancies, deficiencies, and DRRS METs evaluated, to the MRC for review and discussion. Track corrective actions until tested (via subsequent exercise), re-evaluated and closed. Discuss any recommended modifications to the MRTES.

4.3.2.7. UDM Update. Address UTC personnel assignments, highlighting any shortages, vacancies, and hard-to-fill positions. Also brief MRL changes, changes to the status of deployed personnel and any upcoming deployments, if applicable.

4.3.2.8. Deployment AAR Update. The deployed commander or team leader will brief deployment AAR contents. At this time, the MRC will identify any lessons learned appropriate for Air Force-Joint Lessons Learned Information System (AF-JLLIS) input and tracking.

4.3.2.9. Logistics Update. Logistics personnel will provide a review of the inventory schedule, deferred procurement program exercise results, and a status update on BW/CW as well as assets maintained for other organizations. For units with assigned WRM UTC assemblages, brief materiel status at every MRC meeting as long as percentages are less than 100%, and include at a minimum, critical item shortages, open items/lessons learned from the most recent inventory, get-well plan, and projected get-well dates. **Note:** MC-CBRN assemblage updates will be provided by the responsible MCRP team chief(s).

4.3.2.10. Unit Reports Update. Provide an overview of unit SORTS, DRRS ESORTS, and ART status. **Note:** these discussions may be classified. Do not include classified material in the MRC agenda or minutes. Instead, include this statement, or a similar phrase, in the minutes: "Classified report provided and understood by members."

4.3.2.11. Inspection Results Update. Include status of any open items from self-inspections and most recent HSI, ORI, staff assistance visits, etc.

4.3.2.12. Other Topics. Other topics discussed regularly but not necessarily identified as standard agenda items may include: Readiness Case Analysis (RCA) business planning, vulnerability assessment updates, coordination with community leaders regarding response initiatives, Individual Medical Readiness (IMR) statistics, deployed medical intelligence updates, and trip/conference reports.

4.3.3. **Minutes.** Meeting minutes will be prepared in accordance with the format provided in Attachment 4. They will provide a clear, concise summary of discussions and events, and will include sufficient historical information to fully describe issues being discussed. Use MRC minutes to document unit MCRP review and approval, and well as MRTES coordination and approval. Attachments must include data provided, copies of PIES, AARs, handouts and presentation slides, if used.

4.3.3.1. Maintain copies of MRC minutes for the current year plus two additional years.

4.3.3.2. A suggested MRC presentation template may be found on the AF Medical Readiness CoP.

4.3.3.3. Submit MRC minutes to MAJCOM/SGX as required by MAJCOM policy or elevate significant issues requiring higher headquarters resolution.

Chapter 5

MEDICAL READINESS PLANNING

5.1. Unit Level Planning. Unit level planning is critical to ensuring the unit is capable of meeting its expeditionary and emergency management missions. It includes developing unit plans and providing input to wing and local community plans. In the broader sense, unit planning also includes those activities which prepare unit personnel to execute expeditionary and emergency management missions.

5.2. Global Operations Planning. Global medical operations' planning is initiated at the combatant command and air component command levels, but the unit level planner plays an important role in the successful execution of the expeditionary mission. Joint Publication 4-02, *Doctrine for Health Services Support in Joint Operations*, provides doctrine for the planning and execution of force health protection and health service support at the operational level, throughout the range of military operations. AFDD 4-02, *Medical Operations*, addresses Air Force health services doctrine to reflect current AFMS capabilities and how to organize and employ those capabilities in support of expeditionary operations. Supporting tactical doctrine provides more detailed guidance and can be found at: **https://kx.afms.mil/doctrine**. Additionally, unit concepts and procedures for supporting expeditionary operations must be included in the MCRP, which is described in paragraph 5.5 and Attachment 2 of this Instruction.

5.2.1. **Medical Resource Letter (MRL).** The MRL, maintained within MRDSS ULTRA, is the tool designed to manage AFMS readiness resources. Information provided in the MRL for a specific unit includes, but is not limited to: UTCs currently apportioned to the unit; UTCs the unit is projected to gain or lose; whether assigned UTCs are manpower or equipment; AEF assignments (past, present and projected) and tempo bands for each UTC; and for equipment UTCs, which logistics account is responsible for maintaining them and where the assets are physically located. In addition to reflecting current UTC apportionment, the MRL also reflects anticipated changes, including potential UTC transfers, moves, or gains for up to the next five years. The MRL is also utilized to manage the apportionment/distribution of MC-CBRN assemblages (886 AS).

5.2.2. **Additional UTC Planning Resources.** The MRO and MRNCO must be thoroughly familiar with the MISCAPs and MEFPAK Playbooks for all assigned UTCs, as well as any relevant AF Tactics, Techniques and Procedures (AFTTPs), which can also be found at **https://kx.afms.mil/doctrine**.

5.2.3. **Deployment Planning Resources.** AFI 10-401 and AFI 10-403 provide information on the deployment and employment process. The Medical Supplement to the AF War Mobilization Plan, Volume 1 (WMP 1) provides additional guidance. HQ AFPC/DPW also provides planning resources via AEF Online at: **https://aef.afpc.randolph.af.mil**/. Finally, the expeditionary nature of Air Force operations requires extensive planning to ensure proper deployment, beddown, and operation of Forward Operating Locations. The Air Force process for conducting this planning is outlined in AFI 10-404, *Base Support and Expeditionary Site Planning*. Specifically, these plans are called the - In Garrison Expeditionary Site Planning (IGESP) and Expeditionary Site Plan (ESP).

5.3. National Disaster Medical System (NDMS). The NDMS is a federally coordinated system that augments the nation's medical response capability. The overall purpose of the NDMS is to establish a single integrated national medical response capability for assisting state and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas contingency operations (OCO). NDMS is discussed in Emergency Support Function #8 (ESF-8), Public Health and Medical Services, of the National Response Framework (NRF). Supplemental guidance is available on the AF Medical Readiness CoP.

5.3.1. **Federal Coordinating Centers (FCCs).** Designated AF CONUS MTFs serve as FCCs within the NDMS, providing support and leadership to the local hospitals contributing to the NDMS bed capability. Specific guidance for FCCs must be included in the designated MTF's MCRP. See Attachment 2, Annex R.

5.3.2. **Primary Receiving Centers (PRCs).** PRCs are MTFs or VA Medical Centers (VAMC) designated for coordinating and/or providing treatment to sick and wounded military personnel returning from armed conflict or a national emergency. MTFs designated as PRCs will include these specific responsibilities in the following MCRP Annexes: C, Patient Support; D, Casualty Management; L, Patient Administration; O, Transportation; V, Aeromedical Evacuation; X, Facility Expansion.

5.3.3. **Secondary Support Centers (SSCs).** SSCs are MTFs or VA Medical Center (VAMC) designated to accept transfers from, or sharing resources with, a PRC to maximize health care services support to the DOD. The AFMS has one SSC (59th Medical Wing, Wilford Hall, supporting Brooke Army Medical Center, Ft Sam Houston).

5.4. Emergency Management Planning. In addition to the expeditionary capability of the warfighting mission, AFMS MTFs play an important role in the protection of AF installations. AF overseas MTFs also support the defense of overseas installations and provide support to the host nation through requests from the Department of State and with local MAAs.

5.4.1. **Medical Counter-CBRN Planning**. MC-CBRN planning includes local base/wing requirements and vulnerabilities as identified in the CEMP 10-2. Specific vulnerabilities/threats and planned response should be discussed at the MRC/EMC and incorporated into the MCRP and MRTES. Topics to consider include: management of casualties, including CBRN casualties; awareness of the types of disasters that medical personnel might respond to; and protection and decontamination of medical personnel, patients, and medical facilities during CBRN conditions.

5.4.2. **Medical Emergency Responders.** Medical emergency responders are categorized by AFI 10-2501 and are further defined below to facilitate discussions in installation and medical plans and to determine training requirements according to federal law, DoD and AF guidance. **Note:** OSHA considers first receivers to be a subset of first responders; however, AFI 10-2501 categorizes first receivers as emergency responders.

5.4.2.1. First Responders are defined as personnel who immediately deploy to the disaster scene as part of the disaster response force (DRF) to provide initial command and control (C2), save lives, stabilize the incident, and to suppress/control hazards. Medical first responders are dispatched to the scene at the request of the Incident Commander and typically include ambulance services or flight medicine.

5.4.2.2. Emergency Responders are defined as personnel who deploy to the scene after first responders in order to expand C2 or perform support functions. Medical emergency responders are follow-on medical teams dispatched to the scene in support of the first responders, such as the field response team, as well as non-clinical medical teams requested by the Incident Commander, such as bioenvironmental engineering.

5.4.2.3. First receivers are a subset of emergency responders who receive potentially contaminated victims for treatment at the medical facility, and typically include clinicians and other medical staff who have a role in receiving and treating contaminated victims (triage, decontamination, clinical services, security, etc.) and those whose roles support these functions (manpower, patient administration, etc.). First receivers also decontaminate, triage, and treat self-reporting victims who have been contaminated by hazardous substance(s) during an emergency event.

5.4.3. **Medical Continuity of Operations (MCOOP) Planning.** MCOOP planning is defined as the medical-unique form of COOP planning directed by AFI 10-208, *Continuity of Operations (COOP) Program*. It differs significantly from what was formerly recognized as the Alternate Medical Facility (AMF) concept in that the intent is to evacuate and disperse patients as rapidly and safely as possible, staging them in a pre-designated location and providing necessary medical care only until dispersal activities are complete. MCOOP does not involve relocating vast amounts of supplies and personnel to an alternate location for the purpose of continuing routine patient care, although units that have the capacity or responsibility to continue to provide services to AD base populations may plan to do so.

5.4.3.1. For MCOOP, the core mission essential functions (MEF) to be addressed in the MCRP include (in priority order): 1) medical command and control for the evacuation and dispersal; 2) patient support, to include facility evacuation, dispersal, transportation, tracking, and pandemic response; 3) staff support, to include evacuation, dispersal, and accountability; 4) medical emergency response activities, to include critical installation support; 5) Command, Control, Communications, Computers and Information (C4I), to include relocation and continuity of medical command and control, as well as information sharing with beneficiaries, staff, and higher headquarters. Units may add additional MEFs based on their unique missions, capabilities, and beneficiary population needs. List and prioritize all MEFs in Annex P, referencing other MCRP annexes as necessary.

5.4.3.2. The Information Services Disaster Response Team (ISDRT) supports MCOOP operations by reacting to disasters or downtime, preventing, and detecting data loss or compromise from further intrusion, recovering and maintaining IS, and coordinating with outside agencies to restore critical systems. Team responsibilities include assessing damage to IS hardware, software, and data; notifying various agencies (AFCERT, MAJCOM, Legal, Public Affairs, etc) as required; ensuring the MTF meets current INFOCON levels checklists; denying access to or shutting down vulnerable systems; and maintaining and prioritizing a list of critical systems and associated administrators of those systems.

5.4.3.2.1. The ISDRT will assist in the response and recovery activities of a disaster or incident that affects the organization's ability to access/control information systems (IS). The team is responsible for coordinating the network / IS recovery process, implementing the activities associated with the recovery and protection of information and supporting medical continuity of operations (MCOOP).

5.4.3.2.2. Common reasons for activating this team may include major hardware failures (e.g., electrical system damage, server crashes, etc.), facility damage (e.g., water leak, structural damage, etc.), communication systems failures (e.g., loss of network connectivity, electronic patient documentation outages, telephone system outages, etc.), and data integrity breaches (e.g., virus attacks, logical security failures, password breaches, etc.). Document all significant IS downtime events requiring ISDRT activation and provide input to the unit's Post-Incident/Exercise (PIES), with input from each affected area/section.

5.4.4. **Defense Support to Civil Authorities (DSCA).** Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the President may direct any federal agency to provide support to State and local agencies. AFI 10-802, *Military Support to Civil Authorities*, and the CJCS DSCA Standing execute order (EXORD), outline how the Air Force will provide support.

5.4.5. **Immediate Response Authority.** Imminently serious conditions resulting from any civil emergency or attack may require immediate action by military commanders, or by responsible officials of other DOD agencies, to save lives, prevent human suffering, or mitigate great property damage. When such conditions exist and time does not permit prior approval from higher headquarters, local military commanders, and responsible officials of other DOD components are authorized by DODD 3025.1, *Military Support to Civil Authorities*, to take necessary action to respond to requests of civil authorities.

5.4.6. **National Response Planning.** Several Federal laws and specific plans outline military support responsibilities for emergency response. The MRO/MRNCO should be familiar with all of these plans. Specific information and taskings are provided in Attachment 8.

5.4.7. **Host Nation Requirements.** For installations outside the United States, support during emergency operations is provided through established host nation support agreements, by direction of the Combatant Command, or upon direction of the installation commander to save lives, prevent human suffering, or mitigate great property damage. Requests for US military support of stability operations and disaster response outside the United States are typically submitted by the host nation through the Department of State (DOS). DOS and/or

DOD teams work cooperatively with the host nation to identify temporary military-specific support capabilities and resources necessary to minimize human suffering. The provision of direct medical services to host nation members will be focused on short-term objectives, transitioning to non-governmental or international organizations as soon as practical.

5.5. Medical Contingency Response Plan (MCRP). The MCRP is the medical unit commander's plan, establishing procedures for the unit's expeditionary missions identified in the Designed Operational Capability (DOC) statement and emergency response missions identified in the CEMP 10-2. The MR office will manage the preparation, coordination, publication, and distribution of the MCRP. See Attachment 2 for the required MCRP format and annex details.

5.5.1. **Special Planning Considerations.**

5.5.1.1. Limited Scope (LS), Limited Scope with Inter-Service Support **(**LSISS) MTFs, deployed MTFs, and non-collocated ARC units are not required to prepare an MCRP. However, these units will conduct a realistic assessment of their contingency response capabilities (including MC-CBRN) and incorporate them into the installation's CEMP 10-2, or sister service equivalent for LSISS MTFs. Use the MCRP team annex guidance in Attachment 2 as the framework for preparing CEMP 10-2 inputs, utilizing the established MCRP team names. Clearly identify MTF capabilities, roles and responsibilities in support of a collaborative installation response, including support provided via MOUs/MOAs/MAAs, as appropriate. Ensure assigned personnel are trained and record this training in MRDSS ULTRA utilizing existing MCRP team names and training requirements outlined in this Instruction and in the Minimum MCRP Team Training matrix provided on the AF Medical Readiness CoP.

5.5.1.1.1. ARC medical units are not required to develop an independent MCRP. However, ARC and Aeromedical Evacuation (AE) units collocated with an active duty MTF are considered available medical resources and must be included in the active duty MTF's MCRP as such.

5.5.1.1.2. Depending on local support available, particularly for OCONUS units, support may be provided by another AF MTF. When this is the case, support to be provided will be included in the supported unit's CEMP 10-2 and be addressed in the supporting MTFs MCRP.

5.5.1.2. Units will develop and maintain current medical response checklists in support of installation plans, addressing unit control center activation, major accident response, natural disaster response, MC-CBRN response, and casualty management, at a minimum. All checklists will be reviewed at least annually and coordinated through the unit's EMC and contributing agencies. In addition, deployed MTFs will include attack response as a potential scenario. Deployed MTF commanders will review response checklists upon assignment and validate procedures at least once each AEF rotation.

5.5.1.3. In the case of multi-service or multi-unit areas, i.e. San Antonio or Colorado Springs, units will discuss their roles in response to a city-wide event and interactions with local emergency management officials (e.g. the city/county emergency management office) in the Basic Plan. Opportunities for a unified response (i.e. city-wide response) to any emergency should be considered as rationale for an integrated MCRP. All integrated

MCRPs must be approved by the parent MAJCOM/SGXs of all affected units prior to publication.

5.5.2. **Plan Organization.** The MCRP will include the following sections: cover page, letter of transmittal, security instructions, record of changes, plan summary, table of contents, basic plan, annexes, and distribution list. All annexes outlined in Attachment 2 must be included. If a particular annex does not apply, annotate the annex as "Not Applicable" and address it in the MRC/EMC meeting, documenting the rationale in the meeting minutes.

5.5.3. **Plan Coordination.** All offices and agencies tasked to provide any kind of support in the MCRP must coordinate on the plan and specifically approve their roles and responsibilities. Coordination may be accomplished via the AF Form 1768, Staff Summary Sheet, or other routing format that provides concurrence by electronic or hard copy signature.

5.5.3.1. For on-base agencies tasked to support the plan, coordination and concurrence on the SSS constitutes agreement with its contents. No additional MOU/MOA/MAA is required. Required on-base coordination includes the wing plans office, Judge Advocate office, and Civil Engineer Readiness and Emergency Management Flight, at a minimum. The wing plans office may require additional plan coordination.

5.5.3.2. Off-base agencies.

5.5.3.2.1. Support to the MTF must be in the form of MOUs/MOAs/MAAs. See paragraph 5.5.6. Approval of the MOU/MOA/MAA constitutes agreement with the plan contents, therefore an additional staff summary sheet is not required.

5.5.3.2.2. Units unable to obtain coordination with an off-base agency must develop a memorandum for record (MFR) and attach all correspondence (e-mails, memos, phone records, etc.) to document their attempts to gain formal coordination.

5.5.3.3. Submit a copy of the draft MCRP to the parent MAJCOM/SGX for review after full coordination with applicable agencies and MRC/EMC approval, but prior to publication. Plan reviews will be accomplished by MAJCOM/SGXs within 60 days. Concurrence is implied if no comments from the MAJCOM are received within that period.

5.5.4. **Plan Review.** The MRC must review the MCRP annually and documentation of the review recorded in the minutes. Team chiefs will also review and update their respective annexes and checklists annually. Minor changes may be corrected with replacement pages, but must be coordinated with all affected agencies and distributed according to the original plan distribution. The MCRP will be rewritten at least every three years or when the number of changes is significant (35% of the document), whichever is sooner. This will ensure a thorough review of wing and medical unit mission changes, as well as civilian community growth and local infrastructure changes. Update the MCRP publication date in MRDSS ULTRA once the plan is published.

5.5.5. **Plan Distribution.** Distribute copies of the MCRP and appropriate checklists to each office that plays a role in its execution. The MR office will maintain additional copies for transfer to the shelter, Medical Continuity of Operations (MCOOP) alternate C2 location, and the installation EOC, as applicable. The MCC will maintain a master copy of all MCRP supporting checklists.

5.5.6. **Memorandums of Understanding (MOUs), Memorandums of Agreement (MOAs), and Mutual Aid Agreements (MAAs).** Support to the MTF from off-base agencies must be coordinated in writing, in accordance with AFI 25-201, *Support Agreements Procedures*. Do not duplicate existing agreements and contracts, such as the TRICARE contract. Coordination documentation for MOUs/MOAs/MAAs that support the MCRP must be kept in the MR office.

5.5.6.1. The MOU/MOA/MAA must include specific details associated with the agreement, to include levels of support for various types of emergencies. Agreements should be established for the following capabilities at a minimum:

5.5.6.1.1. Cooperation with the community healthcare system and emergency response organizations to leverage medical response capabilities that exist outside the installation.

5.5.6.1.2. Utilization of facilities to carry out quarantine, isolation, and/or pharmacy dispensing activities beyond the MTF's capability.

5.5.6.1.3. Transportation of casualties beyond the MTF's capability. Include resources for transporting potentially contaminated casualties.

5.5.6.1.4. Reception of casualties, to include contaminated casualties, by off-base hospitals.

5.5.6.2. Ensure MTF response planning includes integration and coordination with follow-on response capabilities from local, state, and federal agencies.

5.5.6.3. The Executive Staff, MRC/EMC members, wing plans office, Judge Advocate office, and Civil Engineer Readiness and Emergency Management Flight must review emergency management and contingency MOU/MOA/MAAs before final approval. Document the review on an AF Form 1768, *Staff Summary Sheet*, or by electronic coordination methods. MRC/EMC review may be documented in meeting minutes.

5.5.6.4. MOU/MOA/MAAs for MCRP support will be reviewed annually and reaccomplished when there are significant changes.

5.5.6.5. AFI 25-201 delineates the minimum support requirements for AFRC and ANG units located on installations where there is an Active Duty Host. MOUs/MOAs/ MAAs and HTSA are required in addition to the minimum support requirements outlined in para 3.2.2.

Chapter 6

MEDICAL READINESS TRAINING

6.1. Training Philosophy. All medical personnel must be fully trained to meet the task requirements associated with home station and global operations. Requirements are defined through METs, determined by MRA, MAJCOM/SGXs, and AF guidance. The METs are listed in TTP documents or MRA Playbooks. For specific training requirement and timeframes, ARC personnel should see Chapter 10 for additional ARC-specific guidance.

6.1.1. **Foundational Training.** All Airmen, regardless of rank, fill a duty AFSC (DAFSC). Airmen are trained to initial proficiency upon entry into the Air Force, or join the Air Force with verifiable AFSC-specific credentials. Enlisted personnel receive initial medical readiness training through the Expeditionary Medical Readiness Course (EMRC) or Basic Expeditionary Medical Readiness Training (BEMRT) in conjunction with their AFSC-awarding courses. Officers receive initial medical readiness training as part of the Commissioned Officer Training (COT) or Reserve Commissioned Officer Training (RCOT) courses, or through a commissioning program such as a service academy, Reserve Officer Training Course (ROTC) or Officer Training School (OTS). Additionally, professional credentials and other foundational training/education sources may contribute to an individual's training status. This Instruction addresses training that builds upon these foundational skills, including the initial readiness lectures, field training, and exercises provided in accession training. See Attachment 3, Table A3.5 for required field training topics.

6.1.2. **Training Continuum.** Training may be focused to achieve success at the individual, team or leader level. The ability of Airmen to perform their individual tasks is the most critical aspect of team performance. Together, conditions, performance standards and criteria for each task form the individual training objectives and assessment criteria and are used by supervisors and instructors to ensure full capability. The next organizational level for training is the team level. The term "team" includes both UTCs and MCRP teams. Team training should be conducted after individuals attain proficiency in individual tasks but before the team is expected to perform unassisted in an exercise or deployment. It is understood that some exercises and courses are designed to enhance individual and team proficiency simultaneously; however, when possible individuals should be trained in advance. Teams with installation response missions may be called upon to perform installation functions in exercises or real world operations at any time and therefore should be trained on those functions. Leaders will be trained in applicable joint and Service doctrine to ensure effective C2, required support, and reachback utilization.

6.1.3. **Training Categories.** Medical Readiness training requirements identified in this Instruction are grouped as Category I, II or III. Individual training requirements are classified as Category I and are required for all medical personnel, and in some cases assigned non-medical personnel, civilians, and contractors, regardless of their deployment status. Category II includes training required for medical personnel assigned to standard deployable UTCs. Medical personnel must complete all Category I and II training prior to entering their deployment vulnerability period and ensure completed training remains current for the duration of the vulnerability period or associated deployment. This includes

personnel assigned to standard UTCs identified to support the CBRN Consequence Management Response Force (CCMRF). Category III consists of MCRP team training and AFMS and unit mission briefings and is accomplished at the unit level for all assigned personnel. Specific requirements for each category are listed in Attachment 3, Tables A3.1 through A3.3.

6.1.4. **Interoperable Training.** Interoperable training refers to joint or combined training which synchronizes and integrates force capabilities. Additionally, interoperable training acknowledges individual Service capabilities and limitations, and promotes solutions to maximize all forward-deployed assets to achieve the theater mission.

6.1.5. **Life Support Training.** Personnel holding certain clinical AFSCs who are assigned to standard deployable UTCs may be required to maintain currency in Basic Life Support (BLS), Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), National Registry of Emergency Medical Technicians (NREMT), Prehospital Trauma Life Support (PHTLS), or other life support training, in accordance with AFI 44-102, *Medical Care Management*. For personnel assigned to FFZZZs, training can be conducted just-in-time if not already an RSVP or specialty requirement.

6.1.5.1. Required life support training certifications must remain current throughout any projected deployment vulnerability period and will not lapse during a deployment. Training or certifications that are due to expire during an individual's vulnerability period must be reaccomplished prior to entering the vulnerability period to ensure currency.

6.1.5.2. Education and Training (E&T) office personnel will validate requirements for each specialty and track this training in MRDSS ULTRA. Representatives from the E&T office will be given MRDSS ULTRA accounts by the MRDSS ULTRA Unit System Administrator in the MR office to track E&T items. Larger facilities may designate a second MRDSS ULTRA Unit System Administrator in the E&T office specifically to manage E&T accounts.

6.1.6. **Training While Deployed.** Personnel assigned to a deployed unit are required to be fully trained prior to deployment. Therefore, deployed units are not expected to conduct medical readiness training. However, personnel should take full advantage of any training opportunities provided, to include joint training with coalition partners, sister services, host nation medical forces, and others. Upon return to home station, personnel may receive credit for training accomplished during deployment in accordance with paragraph 6.8 of this Instruction

6.1.7. **Limited Scope (LS) and Limited Scope with Inter-service Support (LSISS) MTFs.** LS MTFs and LSISS MTFs are required to accomplish Category I and Category III training as described in this chapter. LS and LSISS MTFs will conduct Category III: Unit Training – MCRP Team Training, based on unit capabilities and support they are required to provide (see paragraph 5.5.1.). If the unit has personnel assigned to standard UTCs, Category II training is required for those individuals.

6.2. Training Administration and Documentation. Conducting a rigorous training program involves full participation from unit leadership, tasked instructors, the MRO/MRNCO, and all trainees. Additionally, documenting all aspects of training activities provides the baseline for further certification and competency verification.

6.2.1. **Training Office of Primary Responsibility (OPR).** The MR office serves as the primary focal point for unit medical readiness training activities. Local MR offices may direct questions to MAJCOM/SGXs, MRAs, and other medical readiness subject matter experts, as necessary.

6.2.2. Personnel in Non-standard Training Situations.

6.2.2.1. Interns, residents, students, including those enrolled in Health Professions Scholarship Program (HPSP), and personnel in fellowship training status are exempt from medical readiness training unless tasked to deploy or assigned to a standard UTC or MCRP team. However, participation in local training and exercises is highly recommended when opportunities are available.

6.2.2.2. Recognizing all medical personnel must maintain a baseline training standard, personnel assigned to SMEs or medical Geographically Separated Units (GSUs) will complete the requirements in this chapter, as well as specialized training for their unique medical missions. MAJCOM/SGXs may facilitate training by pairing these units with a larger MTF, if necessary.

6.2.2.3. Medical Institutional Force (IF) personnel (those assigned to higher headquarters, such as MAJCOMs and the Air Staff) will complete the Category I requirements identified in this chapter and summarized in Attachment 3, Table A3.1. In addition, when assigned to a standard deployable UTC or tasked to deploy, these personnel will complete Category II requirements listed in Attachment 3, Table A3.2. A unit training monitor will be appointed to schedule, track and document staff training.

6.2.2.4. Nonmedical personnel assigned to a deployable medical UTC, including but not limited to First Sergeants and commander's support staff (CSS) personnel, will satisfy all of the applicable Category II requirements described in this chapter.

6.2.2.5. Chaplain Service personnel assigned to an MTF are encouraged to participate in medical readiness training. The MR office will coordinate with the senior chaplain to schedule this training.

6.2.2.6. IMAs attached to MTFs for training must accomplish the training in accordance with Chapter 10.

6.2.3. **Training Documentation**. Document in MRDSS ULTRA all medical readiness training for all medical and non-medical personnel assigned to a medical unit. This system is the sole source of documentation for medical readiness training. Print and file an AF Form 1098, *Special Task Certification and Recurring Training*, in the member's training folder only when the individual is scheduled to PCA, PCS, deploy, separate, or retire. For deployment actions see paragraph 6.2.3.1 below.

6.2.3.1. Prior to an enlisted member's deployment to an AF overseas contingency operation, the unit AFSC functional manager must review each individual's Air Force Training Record (AFTR) and MRDSS ULTRA record. The member's RSVP checklist and individual AF Form 1098 must be printed from MRDSS ULTRA, reviewed, scanned, and uploaded to the individual's AFTR. The purpose of the review is to ensure training is current and will remain current for the duration of the deployment. The reviewer must

document this review on the individual's AFTR AF Form 623A and email the record to the organizational mailbox for the receiving deployed AF unit.

6.2.3.1.1. For personnel deploying to non-AF units overseas, the AFSC functional manager will conduct the same review but once the review is complete, print the training record and give it to the individual to hand carry to the deployment location, if required.

6.2.3.1.2. While the member is deployed, all training accomplished must be documented on a paper AF Form 797, *Job Qualification Standard Continuation/Command JQS*, AF Form 1098, and/or AFTR 623A, as appropriate. When the individual returns from deployment, the form(s) must be scanned and attached to the member's AFTR. In addition, RSVP training will be annotated on the RSVP checklist.

6.2.3.2. Equivalency training (see paragraph 6.7) must be documented in MRDSS ULTRA and supporting documentation, to include certificates, rosters, and waiver letters, must be maintained in appropriate individual or team folders.

6.2.3.3. SMEs, or other medical personnel assigned to LAF units, will contact collocated MTFs for MRDSS ULTRA support to meet requirement to track medical readiness training in this system. AFSOC OSM flights track their own training in MRDSS ULTRA.

6.2.3.4. Training documentation for inspection purposes can be obtained from MRDSS ULTRA reports. For additional information, see Chapter 3.

6.3. Category I: Individual Training. Individual training is a broad categorization that consists of core training that all AFMS personnel must complete. Individuals begin Category I training and are counted in unit training statistics upon in-processing at their first duty station. Category I training consists of medical AFSC-Specific Training, and CBRNE EPRC requirements. It is included in unit training statistics upon the individual's inprocessing.

6.3.1. **Category I: Individual Training - AFSC-specific Training. Readiness Skills Verification Program (RSVP).** RSVP training applies to all individuals who hold a medical AFSC. It represents the minimum skills required for an individual to perform the duties associated with their AFSC during expeditionary and installation response contingencies. RSVP training should begin as soon as personnel arrive at their first duty stations, in accordance with guidance provided by the consultant/CFM for each specialty, with credit awarded as applicable for skills learned in technical training or professional education. For ARC units, RSVP training begins when an individual returns to the unit after completion of their 3-level AFSC-awarding technical school. All RSVP training must be complete prior to deployment.

6.3.1.1. Personnel must complete RSVP training for their CAFSC for enlisted and DAFSC for officers.

6.3.1.1.1. Personnel who are utilized as authorized substitutes on a standard UTC must complete RSVP training for the AFSC they are filling on the UTC, as well as their own. Exceptions to this policy must be approved by the specialty consultants or CFMs of both AFSCs.

6.3.1.1.2. For the Patient Decontamination Team, UTC FFGLB, authorized substitutes will complete RSVP training for their own AFSC only.

6.3.1.2. IF personnel may accomplish RSVP just-in-time (JIT), upon receipt of a deployment tasking. Contact the appropriate consultant or CFM to determine RSVP requirements for commanders on G series orders (non-temporary).

6.3.1.3. BE IF personnel are required to complete E-PACs and the RSV web tool and will complete remaining RSVP requirements JIT or upon reassignment. 043E and 4B0X1 O-6s and E-9s and BE Commanders on (non-temporary) G series orders are exempt from completing the RSV web tool, E-PACs and PAT QUSI assessments, however, all are recommended as time allows. Primary 43Es and 4B0Xs AFSCs assigned to USAFSAM who are designated in writing as E-PAC/QUSI program managers are exempt from the specific program they manage, but are still required to complete the RSV web tool. 043Es and 4B0X1s assigned to 43EA,B,D positions on a medical UMD (regardless of local utilization) are required to complete all RSVP requirements, including the RSV web tool, E-PACs and PAT QUSI assessments unless exempted by other circumstances described in this paragraph.

6.3.2. **Category I: Individual Training - AFSC-specific Training. Centers for Sustainment of Trauma and Readiness Skills (C-STARS).** C-STARS platforms are military-civilian partnerships that provide advanced sustainment training at specific civilian Level-1 trauma centers.

6.3.2.1. C-STARS attendance is required every 24 months for providers, nurses, and clinical technicians as listed on the C-STARS Training Matrix available on the AF Medical Readiness CoP and must be completed a minimum of 30 days prior to the individual's deployment vulnerability period. In addition, AF/SG consultants and CFMs for LS/HD specialties may select personnel from other UTCs, including FFZZZ, to attend C-STARS based on individual circumstances, CBD prioritization, operational or surge requirements, ensuring completion timelines are met. Other personnel may attend C-STARS on a space-available basis.

6.3.2.1.1. Waivers to the 24 month attendance requirement must be approved in writing by the specialty consultant and submitted through the parent MAJCOM/SGX to USAFSAM/ETS (AFEMSI). If the individual is deploying, a copy of the waiver will be submitted by the consultant or CFM to the AFFOR/SG (for example, AFCENT/SG, or as indicated on the C-STARS Training Matrix) for information. The waived individual will submit a copy of the waiver to the MR Office for documentation in MRDSS ULTRA. Maintain a copy (printed or electronic) of the waiver document until the end of the individual's deployment vulnerability window.

6.3.2.1.2. C-STARS exemptions may be granted on a case-by-case basis by the specialty consultant or CFM and will be re-validated every 24 months. If the individual is deploying, a copy of the exemption will be submitted by the consultant or CFM to parent MAJCOM/SGX with courtesy copies to USAFSAM/ETS (AFEMSI) and the AFFOR/SG (for example, AFCENT/SG, or as indicated on the C-STARS Training Matrix) for information. The exempted individual will submit a copy of the exemption to the MR Office for documentation in MRDSS ULTRA. Maintain a copy (printed or electronic) of the exemption document for 24 months. If

re-validated, maintain updated copies of exemption re-validations until the exemption is lifted.

6.3.2.1.3. C-STARS credit may be granted by the specialty consultant or CFM based on STARS-P participation in accordance with paragraph 6.3.3.4.

6.3.2.1.4. Surgeons tasked to deploy should make every attempt to attend the Emergency War Surgery Course (EWSC) prior to deployment, regardless of whether they are required to attend C-STARS. In addition, thoracic (45S3A), cardiac (45S3C), vascular (45S3E), and trauma (45S3K) surgeons practicing in their specialties may be exempt from C-STARS but are required to attend the EWSC prior to deployment.

6.3.2.1.5. C-STARS training is highly encouraged for family practice physicians (44F3) assigned to FFPCM or other standard deployable UTCs. The Family Medicine Consultant may direct specific deploying family practice physicians to attend C-STARS based on a projected deployment location or operational requirement.

6.3.2.2. MR offices should consider limited C-STARS class sizes in the scheduling process and appropriately stagger their personnel over several classes. The student application process includes the submission of an extensive credentialing package required by host institutions. Students must meet the institutional deadlines specified in the credentialing package or their attendance will be subject to cancellation. The approval authority for exceptions or extensions to the deadlines is USAFSAM/ETS (AFEMSI).

6.3.2.3. C-STARS training attendance cancellations must be submitted a minimum of 45 days prior to the class start date. Units and MAJCOM/SGXs should make every effort to find a replacement locally or within the MAJCOM. If it is within the 45-day window and no replacement student is available, the request for cancellation will be signed by the medical unit commander and submitted through the parent MAJCOM/SGX to USAFSAM/ETS (AFEMSI).

6.3.2.4. C-STARS is considered UTC training, specifically the CCATT Advanced Course, for FFCCE, FFCCN, FFCCT and FFQE4 personnel. Only AMC/SG approved C-STARS platforms are authorized for these UTCs and attendance may only be waived by AMC/SG. See paragraph 6.4.7 of this Instruction for specific guidance.

6.3.3. **Category I: Individual Training - AFSC-specific Training. Sustainment of Trauma and Resuscitation Skills Program (STARS-P).** STARS-P is designed to maintain the trauma and resuscitative skills of medical personnel assigned to specified MTFs by regular immersion in on-going clinical rotations at nearby civilian Level-1 trauma centers. By utilizing a core curriculum and advanced human patient simulators, teams may be trained and qualified at a STARS-P platform.

6.3.3.1. STARS-P participants may include AFSCs listed on the C-STARS Training Matrix and eligible members assigned to the following UTCs: FFCCD, FFCCF, FFCCG, FFCCH, FFCCL, FFCCU, FFCCV, FFCLB, FFDAB, FFEDN, FFEDP, FFEDT, FFEP1, FFEP3, FFEP5, FFGKN, FFGKT, FFMFS, FFMSU, FFPCM, FFQE3, FFQEK, FFSTS, FFSVS, FFVCF, FFVNF, and FFVSF. Specialty consultants may also recommend

STARS-P participation for specific individuals based on C-STARS availability, CBD prioritization, operational requirements, or other factors.

6.3.3.2. Participating personnel will regularly rotate through the STARS-P location throughout the year, unless they are deployed, TDY, or on leave. Rotations will be considered part of normal duty. Rotations will consist of at least two shifts per month, or one full week every three months. Rotate personnel more often if the MTF schedule will allow. AD personnel will not be granted STARS-P credit for off-duty employment.

6.3.3.3. To provide currency, STARS-P platforms must provide minimum individual currency events and objectively evaluated team-based trauma resuscitation training and testing curriculum, to include evaluations and scenarios as directed by USAFSAM. Simulator facilities will be utilized for team-based trauma resuscitation and stabilization training, and for individual procedural-based skills training, when the procedure is not completed during ward rotations.

6.3.3.4. Individuals who are required to attend C-STARS and are actively participating in STARS-P programs will attend C-STARS training every five years. Individuals who are not able to participate in STARS-P, or who fail to meet established resuscitation standards set forth by USAFSAM/ETS (AFEMSI) and the specialty consultants, will participate in C-STARS Baltimore or C-STARS St. Louis as prescribed in paragraph 6.3.2 of this Instruction. Waivers or exemptions to STARS-P requirements must be approved in writing by the specialty consultant or CFM through the parent MAJCOM/SGX to USAFSAM/ETS (AFEMSI). If the individual is deploying, a copy of the waiver/exemption will be submitted by the consultant or CFM to the AFFOR/SG (for example, AFCENT/SG, or as indicated on the C-STARS Training Matrix) for information. The waived/exempted individual will submit a copy to the MR Office for documentation in MRDSS ULTRA.

6.3.3.5. STARS-P is not an authorized substitute for the CCATT Advanced Course required for FFCCE, FFCCN, FFCCT, or FFQE4 personnel. These members must follow requirements prescribed in paragraph 6.4.7.3.

6.3.3.6. STARS-P participation will be documented in MRDSS ULTRA.

6.3.4. **Category I: Individual Training - CBRNE Emergency Preparedness and Response Course (EPRC).** CBRNE EPRC is required for all DOD medical personnel. In addition, non-medical personnel working in or assigned to an MTF are required to accomplish this training as well. AFMS new accessions are required to accomplish CBRNE EPRC within 12 months of arriving at their first duty station. Sustainment training must be completed every 36 months, once the sustainment courses are available. Depending on an individual's AFSC and duties, they will complete one or more of the four CBRNE EPRC courses described below and ensure that their training is documented in MRDSS ULTRA. The requirements for completing Medical Effects of NBC Warfare and Threat and Future Battlefield training prescribed in DODI 1322.24, *Medical Readiness Training*, as well as Depleted Uranium training are met through completion of Clinician/Provider or Operator/Responder CBRNE EPRC.

6.3.4.1. Clinician/Provider Course. This course is required for all personnel with a physician, nurse, dentist, physician assistant or IDMT primary AFSC (PAFSC).

6.3.4.2. Executive/Commander Course. This course is required for personnel filling a C-prefix (commander), or having a 40C0 or 9G100 (group superintendent) duty AFSC. Personnel will be granted credit for the Executive/Commander course if they have completed either the Clinician/Provider or Operator/Responder courses, as appropriate for their PAFSC. Personnel who complete the Executive/Commander course and are subsequently reassigned to a non-command position must also complete the course appropriate for their AFSC within 120 days of reassignment. Unit Medical Readiness Training Managers will ensure commanders' duty AFSCs are appropriately entered in MRDSS ULTRA and updated as necessary.

6.3.4.3. Operator/Responder Course. This course is required for all personnel holding a medical PAFSC who do not meet the criteria in paragraph 6.3.4.1 for the Clinician/Provider and Executive/Commander courses. Personnel assigned to the MR office must also take the Operator/Responder course, regardless of their PAFSC.

6.3.4.4. Basic Course. This course is required for all personnel holding a non-medical AFSC (i.e. 3S2XX, 8F0XX) but working in a medical unit or medical staff position.

6.3.4.5. Medical Civilian and Contractor Personnel. Civilian and contractor personnel will take the same course(s) as military members in their positions. For example, a contractor dentist would complete the Clinician/Provider course. Training for these individuals is also tracked in MRDSS ULTRA.

6.4. Category II: Deployment Training. Category II training includes UTC-specific training and human remains preservation training. Additional training, such as Medical Ethics and Detainee Operations Training may be required for some deployers through deployment line remarks. Personnel assigned to UTCs that do not have formal UTC courses, such as those identified for enduring operations, will accomplish training as specified in paragraph 6.4.8. Course descriptions and guidance are provided below and in Attachment 3, Table A3.2.

6.4.1. **Category II: Deployment Training – UTC-Specific Training.** AD personnel assigned to deployable UTCs will complete UTC-specific training within 6 months of assignment to the UTC and as outlined in the following paragraphs, unless otherwise directed by the MRA or higher authority. ARC personnel will complete UTC-specific training within 12 months of assignment. Personnel assigned to standard UTCs who have attended UTC-specific training will remain on that UTC for a minimum of 24 months, or until they PCS, whichever is soonest.

6.4.1.1. Credit for UTC-specific training is provided only by attending the UTC courses. There is no UTC-specific training equivalency credit. The only waiver authorities for this training are the appropriate MRA.

6.4.1.2. Field training is accomplished as part of UTC-specific training. See Attachment 3, Table A3.5 for required field training topics.

6.4.1.3. UTC sustainment training is accomplished between course attendance cycles and is designed to keep UTC members' skills current.

6.4.1.4. The unit MR training manager must schedule personnel to attend UTC-specific training through the parent MAJCOM/SGX at least four months prior to the course start

date, ensuring course completion a minimum of six months before each individual's deployment vulnerability period.

6.4.2. **Category II: Deployment Training – UTC-Specific Training. Contingency Preventive Medicine (CPM) Course.** Global Reach Laydown (GRL) UTCs must complete the CPM course in addition to Category I training. The CPM course is one-time initial training required upon assignment to an FFGRL position. Sustainment training for GRL members involves participation in an Eagle Flag exercise conducted by the Air Force Expeditionary Center at Ft Dix, New Jersey (or other MRA approved exercise) at least once every 48 months.

6.4.3. **Category II: Deployment Training – UTC-Specific Training. Expeditionary Medical Support (EMEDS) Course.** Personnel assigned to EMEDS UTCs attend training as listed below:

6.4.3.1. UTCs FFDAB, FFEP1, FFEP2, FFEP3, FFEP6, FFF0C, FFPCM, FFPM1, FFPM2, FFPM3, and FFMFS attend the EMEDS course every 48 months, alternating with sustainment training at the 24 month point.

6.4.3.1.1. EMEDS Basic personnel assigned to UTCs FFDAB, FFEP1, FFEP2, FFEP6, FFF0C, FFPCM, FFPM1, FFPM2, and, FFMFS sustainment training is conducted every 48 months, alternating with EMEDS course attendance at the 24 month point, and consists of participation in Silver Flag, an RTOC-sponsored, or MRA-approved UTC MET-driven exercise. If an exercise is not available, personnel must return to the EMEDS course for training. EMEDS UTCs cannot receive sustainment training credit for two consecutive 24 month periods.

6.4.3.1.2. EMEDS+10 (UTCs FFEP3 and FFPM3) and EMEDS+25 (UTCs FFEP4 and FFEP5) personnel will complete sustainment training by reviewing the UTC TTP, MISCAPS, METLS and allowance standards.

6.4.3.2. For ANG units, initial EMEDS training will be conducted at Camp Bullis for newly assigned EMEDS UTC personnel and any personnel identified for deployment in support of overseas contingency operations (OCO). For sustainment training (24 months after initial EMEDS course attendance), units may receive training at Alpena Medical Readiness Training Site (MRTS); Camp Bullis (on a space available basis); MRA-approved, UTC METL-driven exercise; or any Mobile Training Team (MTT) venue. For 48-month UTC-specific training, units may receive training at either Alpena MRTS; Camp Bullis (on a space available basis); or a Mobile Training Team (MTT) venue. **Note:** UTC course attendance is required every 48 months with sustainment training occurring mid-way at the 24-month period. Sustainment training cannot be accomplished in two consecutive 24-month cycles. If an exercise is not available for sustainment training, personnel must return to the EMEDS course.

6.4.3.3. EMEDS course attendance will be scheduled as follows:

6.4.3.3.1. For active duty, EMEDS course submissions will be sent to the ACC/SGX EMEDS course scheduler no later than 90 days prior to class start date. The EMEDS scheduler will compile and return the master class roster the MAJCOM POCs no later than 60 days prior to class start date. MAJCOM POCs will validate their personnel, make changes if required, and return the roster to the EMEDS scheduler by the

suspense date. Cancellations for EMEDS training must be submitted a minimum of 30 days prior to the class start date. If within the 30-day window and no replacement is offered, a request for cancellation should be signed by the MTF commander and submitted to the MAJCOM/SGX office. MAJCOM/SGX offices will concur/non-concur and forward the request to HQ ACC/SGX via e-mail or fax. Within 14 days prior to class start date, justification for removal/substitution is limited to emergency leave, hospitalization, profile or early deployment. Cancellations are not accepted after the class start date and any student with an obligated training line number failing to report to class will require a no-show acknowledgement letter signed by the MTF commander and submitted to HQ ACC/SGX within seven days.

6.4.3.3.2. AFRC personnel, in conjunction with their unit, will submit an AF Form 101, *Reserve Requirements For School Tours Of Active Duty For Training,* to their wing training office to receive a Training Line Number (TLN) to attend the course. When the AF Form 101 is submitted, the unit will provide HQ AFRC/SGX the name, UTC, AFSC, and alternate training dates the individual can attend training. If no seat in the class is available, AFRC/SGX will provide alternate class dates, as needed. AFRC personnel will comply with the submission, cancellation, and no show guidance stated in paragraph 6.4.3.3.1 above.

6.4.3.3.3. For ANG, EMEDS formal training will be scheduled through the NGB/SGAST office. The unit MRO or authorized representative will contact their Base Education Training Manager (BETM) to determine available dates for Camp Bullis or ALPENA MRTS. The MRO will complete a roster template and forward a copy to NGB/SGAST, the ALPENA MRTS POC, and the BETM. The BETM will register the individuals via the Skill Enhancement CoP. For Camp Bullis attendance, ANG personnel will comply with the submission, cancellation and no show guidance stated in paragraph 6.4.3.3.1 above.

6.4.4. **Category II: Deployment Training – UTC-Specific Training. Patient Decontamination Training.** The team chief and NCOIC assigned to Patient Decontamination Team (UTC FFGLB) will attend the Patient Decontamination Course, Number--JCORP4XXX 00AA, provided within six months of assignment. Other FFGLB personnel may attend on a space available basis. Upon completion of the course, the team chief and NCOIC will train the remaining team members using the MCRP patient decontamination assemblage, AS 886A. While this equipment is different from the UTC FFGLA AS 902A equipment, patient decontamination processes are similar and can be practiced using the MCRP team's equipment.

6.4.5. **Category II: Deployment Training – UTC-Specific Training. Aeromedical Evacuation Contingency Operations Training (AECOT).** Personnel assigned to Mobile Aeromedical Staging Facility (MASF) UTCs FFVNM and FFVNP will complete the AECOT CBT and initial AECOT course within 12 months of assignment. MASF personnel will attend AECOT every 24 months for the first three cycles after placement on the UTC, then complete sustainment training every 48 months thereafter. MASF personnel may be granted AECOT sustainment training credit for participation in an RTOC or MRA (AMC/SG) approved exercise. ARC personnel will attend AECOT every 48 months after initial training.

6.4.5.1. For active duty, AECOT class submissions will be sent to the AMC scheduler no later than 90 days prior to class start date. The AMC scheduler will compile and return the master class roster to the MAJCOM POCs NLT 60 days prior to the class start date. MAJCOM POCs will validate their personnel, make changes if required, and return the roster to HQ AMC/SGX (AECOT Course scheduler) by the suspense date. Cancellations for AECOT training must be submitted a minimum of 30 days prior to the class start date. If within the 30-day window and no replacement is offered, a request for cancellation should be signed by the MTF commander and submitted to HQ AMC/SGX via e-mail or fax. MAJCOM/SGX or MAJCOM A3O offices will concur/non-concur. Within 14 days prior to class start date, justification for removal/substitution is limited to emergency leave, hospitalization, profile, or early deployment. Cancellation requests are not accepted after class start date and any student with an obligated training line number failing to report to class will require a no-show acknowledgement letter generated by their MTF commander and submitted to HQ AMC/SGX within seven days.

6.4.5.2. AFRC personnel, in conjunction with their unit, will submit an AF Form 101 to their wing training office to receive a Training Line Number (TLN) to attend the course. When the AF Form 101 is submitted, the unit will provide HQ AFRC/SGX the name, UTC, AFSC, and alternate training dates the individual can attend training. If no seat in the class is available, AFRC/SGX will provide alternate class dates, as needed. AFRC personnel will comply with the submission, cancellation, and no show guidance stated in paragraph 6.4.5.1 above.

6.4.5.3. For ANG, the individual, through their Unit Training Manager (UTM) will submit an AECOT training request to the Base Education Training Manager who will submit it to NGB in accordance with current guidance. Primary and secondary class dates should be listed as noted on the request. NGB will provide alternate class dates to the UTM and/or BETM, as needed, if no seat in the primary or secondary class is available.

6.4.6. **Category II: Deployment Training – UTC-Specific Training. Contingency Aeromedical Staging Facility (CASF) Course.** Personnel assigned to CASF UTCs FFVCF, FFVNF, and FFVSF will attend initial CASF training within 12 months of assignment to the UTC, prior to being deployed, and sustainment training 24 months after attending the course. Sustainment training will be in the form of an MRA approved exercise. UTC-specific course attendance and sustainment training will alternate cycles, with course attendance occurring every 48 months. For example, course attendance will occur one 24 month period and sustainment training will occur the next 24 month period, and course attendance again 24 months after sustainment training. If participation in an exercise cannot be accomplished in the off-cycle, a review of the TTP, and AFI 44-165, *Administering Aeromedical Staging Facilities*, MISCAPS, UTC METLS and allowance standard will suffice as sustainment training. UTCs cannot receive sustainment/exercise credit two consecutive 24 month periods.

6.4.6.1. For active duty, CASF class submissions will be sent to the AMC scheduler no later than 90 days prior to class start date. The AMC scheduler will compile and return the master class roster to the MAJCOM POCs NLT 60 days prior to the class start date. MAJCOM POCs will validate their personnel, make changes if required, and return the roster to HQ AMC/SGX (CASF Course scheduler) by the suspense date. Cancellations for CASF training must be submitted a minimum of 30 days prior to the class start date.

If within the 30-day window and no replacement is offered, a request for cancellation should be signed by the MTF commander and submitted to HQ AMC/SGX via e-mail or fax. MAJCOM/SGX will concur/non-concur. Within 14 days prior to class start date, justification for removal/substitution is limited to emergency leave, hospitalization, profile, or early deployment. Cancellation requests are not accepted after class start date and any student with an obligated training line number failing to report to class will require a no show acknowledgement letter generated by their MTF commander and submitted to HQ AMC/SGX within seven days.

6.4.6.2. AFRC personnel, in conjunction with their unit, will submit an AF Form 101 to their wing training office to receive a Training Line Number (TLN) to attend the course. When the AF Form 101 is submitted, the unit will provide HQ AFRC/SGX the name, UTC, AFSC, and alternate training dates the individual can attend training. If no seat in the class is available, AFRC/SGX will provide alternate class dates, as needed. AFRC personnel will comply with the submission, cancellation, and no show guidance stated in paragraph 6.4.6.1 above.

6.4.7. **Category II: Deployment Training – UTC-Specific Training. Critical Care Air Transport Team (CCATT).** UTC-specific training required for personnel assigned to UTCs FFCCE, FFCCN, FFCCT, or FFQE4 includes the CCATT Initial Course, AECOT, and the CCATT Advanced Course, as described below. Personnel may not be employed or deployed as CCATT members until they have completed the CCATT initial course, AECOT, and CCATT advanced course. They must also complete all additional training requirements as outlined in AFTTP 3-42.51, *Critical Care Air Transport Teams.* All members nominated for CCATT duty will undergo a position-specific skill validation process administered by AFEMSI under the authority of the AMC/SG, the CCATT MRA. Personnel must be approved for CCATT duty through the validation process prior to assignment to a CCATT UTC and entry into the CCATT training pipeline. Reference AFTTP 3-42.51 for the validation process.

6.4.7.1. CCATT Initial Course. All CCATT personnel will attend the CCATT initial course at USAFSAM within 6 months of assignment to the UTC.

6.4.7.2. AECOT. Active duty personnel assigned to CCATT UTCs will complete initial AECOT within 12 months of CCATT initial course attendance; ARC CCATT personnel will attend initial AECOT within 18 months of CCATT initial course attendance. Waivers for initial AECOT attendance for active duty and ARC CCATT personnel may be requested in accordance with AFTTP 3-42.51. AECOT scheduling for these personnel will be in accordance with paragraph 6.4.5 above, 10.5.6, and 10.6.3.3.

6.4.7.3. **CCATT Advanced Course.** Active duty personnel assigned to CCATT UTCs (FFCCE, FFCCN, FFCCT or FFQE4) will complete the CCATT advanced course at an AMC/SG approved C-STARS platform within 12 months following completion of the CCATT initial course, and every 24 months thereafter. ARC CCATT personnel will complete the CCATT advanced course every 48 months, normally beginning in the cycle immediately following the one in which they completed the CCATT initial course. ARC CCATT personnel identified to support a CCATT deployment must have completed the CCATT Advanced Course within the previous 24 months prior to deployment. Personnel who do not successfully complete the CCATT Advanced Course will be ineligible to

deploy and must be replaced. Sufficient lead time is required to ensure the individual, or a designated replacement if the primary fails the course, completes the training successfully prior to deployment. The waiver authority for the CCATT Advanced Course training for CCATT personnel is AMC/SG.

6.4.7.4. All CCATT personnel must complete the requirements for operational support flier (OSF) status in accordance with AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges,* in order to participate in the aerial flight portion of their mission. They must maintain currency in OSF requirements as long as they are assigned to these UTCs. Personnel may not be employed or deployed as CCATT members if they are not current in OSF requirements.

6.4.7.5. OSF-qualified CCATT personnel must be issued aeronautical orders (AO) through the home station Host Aviation Resource Management (HARM) office prior to participating in aerial flight activities. CCATTs must be issued appropriate flying protective clothing and equipment upon initial UTC assignment and for deployment as defined in AFTTP 3-42.51.

6.4.7.6. OSF-qualified CCATT personnel require non-interference AOs, when participating in CCATT training missions.

6.4.7.7. Government passports are required for all CCATT personnel. Refer to memorandum dated 14 Feb 2008 on AMC CCATT website: **https://www.my.af.mil/gcss-af/USAF/ep/globalTab.do?channelPageId=s6925EC13493A0FB5E044080020E329A9**.

6.4.8. **Category II: Deployment Training – UTC-Specific Training. Enablers, Specialty Set UTCs and UTCs for Enduring Operations.** Examples of these UTCs include FFRN1 (enabler), FFGYN (specialty set), and FFMSU (enduring operations). Personnel on these UTCs are not listed in preceding paragraphs and do not have UTC-specific courses. Instead, personnel assigned to these UTCs will review their UTC MISCAPs, CONOPS/TTP, METLs and allowance standards, as applicable, every 24 months. Hands-on experience with equipment is required for those units with collocated equipment sets. Participation in exercises is highly recommended when opportunities are available. A list of standard UTCs identified for enduring operations is available on the AF Medical Readiness CoP in the AFI 41-106 Toolbox.

6.4.9. **Category II: Deployment Training – Human Remains Preservation.** This training is designed to provide an understanding of human remains preservation requirements, procedures for retrieval and processing of remains; cultural implications; and medical planning considerations including technician safety. This DOD-mandated training (reference the 2007 National Defense Authorization Act, section 567) is conducted at the unit level just-in-time (JIT), once an individual is tasked to deploy. The briefing is available on the AF Medical Readiness CoP in the AFI 41-106 Toolbox.

6.5. Category III: Unit Training. Unit training is tailored to meet individual unit characteristics and requirements.

6.5.1. **Category III: Unit Training – MCRP Team Training.** MCRP team training conducted at the unit is designed to maximize team member interaction and role

reinforcement and includes leadership elements. Each MCRP team must train annually to meet capabilities identified in its team annex. Each team chief will clearly identify training requirements and develop an annual training schedule that will be forwarded to the MR office for inclusion in the MRTES. Team chiefs should be aware of additional training levied from other sources, including guidance memos, other AFIs and installation plans, and must document and conduct training as new requirements surface. The Minimum MCRP Team Training Matrix, provided on the AF Medical Readiness CoP in the AFI 41-106 Toolbox, provides a list of current training items. All MC-CBRN team members must maintain proficiency on AS equipment and should add additional training if necessary to achieve this proficiency.

6.5.1.1. **First Receiver and First Responder Training.** For clarification purposes, the roles and training requirements previously identified as "First Responder" for all medical personnel have been divided as described below. AFMSA/SGX has approved standardized First Responder/Receiver training materials for medical emergency responders to provide for and sustain in-house training programs; these materials are available on the AF Medical Readiness CoP. This training is tailored to meet medical emergency responder requirements and allow scheduling flexibility. Medical facilities that are unable to conduct this training in-house will fulfill the requirements though the use of external training sources listed in the HAZMAT Education and Training section of AFI 10-2501.

6.5.1.1.1. First Receiver Awareness level training is required for all personnel who work in the medical facility in support of patient care but are not expected to have contact with contaminated victims, their belongings, equipment, or waste. This includes administrative and ancillary support personnel who work in duty sections that may be first to identify a contaminated patient, such as a door greeter or receptionist.

6.5.1.1.2. First Receiver Operations level training is required for all personnel who have a designated role in the decontamination zone outside the medical facility. These personnel don PPE in order to triage, decontaminate, or treat potentially contaminated patients prior to their entry into the medical facility. This includes personnel assigned to Triage and Patient Decontamination, as well as members of the Manpower/Security Decontamination Support Team and other personnel who meet the definition based on assigned duties.

6.5.1.1.3. First Responder Operations level training is required for any personnel who will respond to the scene of an accident. This includes First Responders and Emergency Responders, as defined in paragraph 5.4.2 of this Instruction, but excludes First Receivers. The portion of the training on PPE should be tailored to the level of PPE used by the team in accordance with local employment concepts as defined in the base CEMP 10-2 and the MCRP. The level of PPE training received must be approved by the BE for adequacy, and coordinated with the base Fire Chief to ensure the training supports the installation's response requirements.

6.5.1.1.4. As required by AFI 10-2501 and 29 CFR 1910.120(q)(6), new members of MCRP teams will be trained to the First Responder Awareness or Operations level, as applicable, prior to being allowed to respond to real world CBRN incidents.

6.5.1.1.5. Refresher training will be conducted annually and may be accomplished by completing the original training again, attending a formal refresher course, or through demonstration of competency during exercises or actual responses. In order to take credit for competency demonstration, the team chief must document the exercise or response, verify individual participation, and address how each training objective was accomplished. All civilians and contractors assigned to MCRP teams will complete the same training required of military members filling equivalent positions.

6.5.1.1.6. Respiratory protection training can be accomplished during First Responder/Receiver Operations Training if approved by the local respiratory protection program manager.

6.5.1.2. **RSVP Training.** Personnel assigned to MCRP teams must be prepared to perform team tasks at any time, regardless of skill level. Therefore, these individuals must maintain currency in RSVP training at all times. To remain current, training for each task must be completed prior to its expiration date.

6.5.1.3. **Team Training Documentation.** Team chiefs will conduct, document, and track training for their teams in MRDSS ULTRA. Lesson plans will be developed and maintained by the team chief and reviewed annually, prior to conducting training. Lesson plans will include training objectives, materials required, time required for training, and method of training, as appropriate. Make-up training for personnel who miss training sessions must be conducted within 60 days of returning to duty and documented in MRDSS ULTRA.

6.5.1.4. **LS and LSISS MTFs.** Use the MCRP team annex guidance in Attachment 2 as the framework for preparing unit input for the CEMP 10-2 (or sister service equivalent), utilizing the appropriate MCRP team names. Utilize the Minimum MCRP team Training Matrix, provided on the AF Medical Readiness CoP to determine team training items and document the training in MRDSS ULTRA.

6.5.2. **Category III: Unit Training – Unit Mission Briefing.** MR office personnel will develop this briefing to be presented during in-processing and annually thereafter. The briefing will include unit-specific expeditionary and home station medical response missions; WRM and equipment assemblage information; local community expectations and capabilities; VA, local, and joint interface opportunities; and other issues as directed by the unit commander. A template for the briefing is available on the AF Medical Readiness CoP in the AFI 41-106 Toolbox.

6.5.3. **Category III: Unit Training – AFMS Mission Briefing.** This briefing presents the basic tenets of the AFMS mission, to include expeditionary, peacetime baseline, and home station medical response, and will be accomplished annually. The current briefing is provided on the AF Medical Readiness CoP in the AFI 41-106 Toolbox.

6.6. Leadership Training (Crosses all Categories).

6.6.1. **Command and Control (C2).** In preparation for leading in the deployed environment, unit and UTC team leaders must fully understand C2 and conditions at the deployed location, using the *Deployed Leaders Guide*, available on AEF Online at **https://aef.afpc.randolph.af.mil**/, as a reference. Additional leadership publications are also available on this site. Specific areas to study to improve situational awareness include:

6.6.1.1. Joint Force commander's mission, concept of operations, phasing, and desired end state.

6.6.1.2. Joint force laydown, including the LAF and medical C2 for operational control (OPCON), tactical control (TACON), administrative control (ADCON), and support.

6.6.1.3. Joint and air component medical concept of operations, including casualty flow from injury to definitive care, blood and medical supply, host nation medical care, casualty estimates, and logistics resupply reach back chain.

6.6.1.4. Theater specific risks and force health protection, including intelligence data on climate, topography, endemic diseases, and environmental factors.

6.6.1.5. Operational mission of the base and their units/teams during all phases of the mission.

6.6.1.6. Population at risk. Although wartime troop strengths are classified, a fundamental understanding of the population at risk, its general size and characteristics, and any variances over time, is essential to effective planning and resourcing.

6.6.2. **Pre-deployment Exercise.** If possible, UTC and/or deployed unit leaders should participate in a pre-deployment tabletop exercise without subordinate unit personnel, to enhance communication with other leaders and theater familiarity. Prior communication with the deployed site is authorized for command and control personnel to enhance mission preparation.

6.6.3. **Pre-deployment Training.** Any required pre-deployment training will be specified in reporting instructions. All personnel must comply with training requirements and carry documentation of training when deploying.

6.7. Joint Training. CJCSI 3500.01E, *Joint Training Policy and Guidance for the Armed Forces of the United States,* defines joint training as "Training, including mission rehearsals, of individuals, units, and staffs using joint doctrine or joint tactics, techniques, and procedures to prepare joint forces or joint staffs to respond to strategic, operational, or tactical requirements considered necessary by the combatant commanders to execute their assigned or anticipated missions."

6.8. Training Equivalency. The AFMS acknowledges professional credentialing, practical experience, and other foundational training/education sources may meet the substance and spirit of specific training requirements. The commander must ensure, either through UTC course attendance, exercises, inspections and deployments, or through equivalency credit, that training is conducted for all assigned missions. Credit may be awarded for specific training elements at all levels, up to and including interoperability training. A unit commander has the authority to assess individuals, UTCs, and their unit as "mission ready." Supplemental guidance for commanders is available as listed below.

6.8.1. **RSVP.** Unit commanders or their designees (appointed in writing) may grant credit for specific RSVP training tasks that are accomplished as part of regular duties, participation in a deployment or exercise, or attendance at UTC training. Documentation must be provided as evidence for each task credited in this manner. For ARC, medical unit commanders may grant credit for specific RSVP training tasks that are accomplished as part

of assigned duties at the member's civilian place of employment. Documentation must be provided as evidence for each task credited in this manner.

6.8.2. **Formal Courses.** Training elements at all levels may be met by formal course attendance. Examples of these courses include EMRC, BEMRT, COT, Combat Casualty Care Course (C4), among others. Formal courses may include other required training elements for which credit may be granted. A full list of included courses/elements is provided on the Medical Readiness Training Equivalency Matrix on the AF Medical Readiness CoP in the AFI 41-106 Toolbox.

6.8.3. **Exercises.** Sustainment training credit may be granted for locally-sponsored UTC Mission Essential Task-driven exercises with prior MRA approval. Local exercises must use UTC equipment packages to qualify for sustainment credit. A list of exercises the MRA has approved for sustainment credit may be found on the applicable MRA's CoP. For exercises not listed, requests for credit should be submitted to the appropriate MRA NLT 60 days prior to the start of the local exercise. Once an exercise is approved for sustainment training credit by the MRA, training participation will be verified by the MR office and updated in MRDSS ULTRA, using the exercise end date as the training completion date.

6.8.4. Deployments.

6.8.4.1. Members may request UTC sustainment training credit for participation in real world operations and/or deployments. Members who have deployed and have performed duties consistent with deploying in their assigned UTC, utilizing the UTC's assigned war reserve materiel (WRM) equipment assemblages in an expeditionary (Bare Base) environment may request UTC sustainment training credit. Requests will be forwarded to the appropriate MRA for approval. If approved, the deployment return date will be used as the training completion date.

6.8.4.2. Members may request GRL equivalency credit for real world operations and/or deployments. Members who have deployed 14 days or more to an austere environment in a 48 month period and have performed duties consistent with deployment as GRL or Preventive Medicine Team (FFPM1/2) may request credit for specific training requirements. Requests will be forwarded to HQ AMC/SGX who will coordinate approval/disapproval with HQ AMC/SGP. If approved, the deployment return date will be used as the training completion date.

6.8.5. **Professional Credentialing.** The unit commander, after consultation with his Executive Staff if required, may award equivalency credit for individual training requirements being met by professional training, credentialing, and daily operations. For example, a medical technician who works in the emergency room and provides bandaging and splinting activities daily does not need to participate in readiness training for basic first aid, bandaging, and splinting.

6.8.6. **Equivalency Documentation.** Medical readiness training equivalency will be documented in MRDSS ULTRA. Supporting documentation, including military or civilian certificates, professional certification, waiver letters, or after-action reports should be maintained if practical.

Chapter 7

MEDICAL COUNTER-CHEMICAL, BIOLOGICAL, RADIOLOGICAL, CHEMICAL, NUCLEAR (MC-CBRN) PROGRAM

7.1. MC-CBRN Program Requirements. MC-CBRN activities generate additional challenges for MCRP teams and team chiefs. This chapter consolidates available MC-CBRN guidance for quick reference and direction; however, AFTTP 3-42.32 provides complete information and should be thoroughly reviewed by all personnel assigned to these teams. This chapter outlines MC-CBRN requirements for AD units; guidance specifically for ARC units is provided in Chapter 10 of this Instruction.

7.1.1. **Allowance Standards.** MCRP teams identified in Table 7.1 have unique responsibilities and allowance standards. These teams must be prepared to provide stabilization and life support for sustained periods of time without assistance from outside agencies. MCRP team chiefs identified in Table 7.1 are responsible for maintaining assigned MC-CBRN allowance standards and meeting team chief responsibilities described in paragraph 2.1.22 of this Instruction. MC-CBRN assets must be stored in ready status and in areas that are easily accessible during duty and non-duty hours. Reference Attachment 5 of this Instruction for MC-CBRN allowance standard (AS) requirements and the MRL (in MRDSS ULTRA) for apportionment guidance.

Table 7.1. MC-CBRN Allowance Standards and Team Associations.

Allowance Standard	Responsible Team Chief	Associated MCRP Team	MCRP Annex
886A, In-Place Patient Decontamination	Patient Decontamination Team Chief	Patient Decontamination Team	Annex N
886D, Inpatient Medical Follow-on	Nursing Services Team Chief	Nursing Services Team	Annex D, Appendix 2
886E, Pharmacy Response	Pharmacy Team Chief	Pharmacy Team	Annex D, Appendix 2, Tab 6
886H, Bioenvironmental Engineering	Bioenvironmental Engineering Team Chief	Bioenvironmental Engineering Team	Annex F
886I, Laboratory Biological Detection	Laboratory Team Chief	Laboratory Biological Detection Team	Annex D, Appendix 2, Tab 5
886J, Field Response	Field Response Team Chief	Field Response Team	Annex D, Appendix 1, Tab 1
886K, Triage	Triage Team Chief	Triage Team	Annex D, Appendix 2, Tab 9
886L, Clinical	Immediate Team Chief, or Clinical Services Team Chief (see para 7.2.8)	Minimal, Delayed, and Immediate Teams	Annex D, Appendix 2, Tabs 1, 2, 3, and 7
886M, Medical Unit Security	Security Team Chief	Manpower/Security Team	Annex H
886P, Public Health	Public Health Team Chief	Public Health Team	Annex E

7.1.2. **Training.** Minimum training requirements for each team listed in Table 7.1 are provided in Tables 7.2 through 7.11 In addition, teams must complete the MCRP team training items listed in the Minimum MCRP Team Training Matrix in the AFI 41-106 Toolbox, on the AF Medical Readiness CoP.

7.1.2.1. Team members completing First Responder/Receiver Operations training are given credit for First Responder/Receiver Awareness training if the training material meets the objectives of Awareness level training.

7.1.2.2. MCRP team personnel who are required to wear respiratory protection must be enrolled in the respiratory protection program and complete all associated requirements (e.g. medical evaluation, fit testing, training, etc.).

7.2. Operations. All MCRP teams must identify how the team will operate in a CBRN environment or to a CBRN event, even if they do not possess MC-CBRN assets, and describe those procedures within their MCRP annexes.

7.2.1. **Patient Decontamination Team.** The Patient Decontamination team fulfills the requirement for medical facilities to effectively receive patients from a CBRN/industrial chemical incident with tailored, fast, light medical decontamination capabilities. The Patient Decontamination team provides the capability to remove or neutralize agents on CBRN incident or accident casualties. The overall goals of the Patient Decontamination team are to save lives, protect the medical treatment personnel and facility, and protect the environment.

7.2.1.1. A minimum of 12 trained medical personnel are required to staff the patient decontamination system and perform decontamination. Minimum training requirements are provided in Table 7.2.

Table 7.2. Minimum Training Requirements for the Patient Decontamination Team.

MCRP Team	Training Requirement	Frequency	Required for
Patient Decontamination (886A)	Patient Decontamination Course	One-time only	Two members of the team (team chief and NCOIC)
	Respiratory Protection Training	Initial and refresher every 12 months	All personnel assigned to the team
	First Responder/Receiver Operations Training	Initial and refresher every 12 months	All personnel assigned to the team
	CBRNE EPRC Operator/Responder Course	Initial and refresher every three years	Clinicians assigned to the team take the CBRNE EPRC Clinician/Provider Course; all others take the CBRNE EPRC Operator/Responder Course

7.2.1.2. The patient decontamination system must be operational within 20 minutes of team activation. The term “activation” in this case is defined as the team is assembled and has been directed to prepare to conduct patient decontamination. Commanders and team chiefs must ensure sufficient additional personnel are trained as augmentees to perform patient decontamination to allow for continual operations and team member work/rest cycles. The 886A AS has sufficient PPE for up to 24 personnel.

7.2.1.3. The 886A AS, Patient Decontamination, is an in-place asset to be utilized only at the medical facility; however, if patient care activities are transferred to another location, this equipment may be relocated to a nearby source of water and electricity. ANG patient decontamination equipment (976A) is mobile and can operate at the MDG facility or another pre-designated site. Prior coordination with logistics or other sections to assist with transporting patient decontamination equipment to the alternate facility is recommended.

7.2.1.4. The Decontamination Team Chief and NCOIC will attend the Patient Decontamination Course, Number--JCORP4XXX 00AA, within six months of assignment. Upon completion of the course, the team chief and NCOIC will train the remaining team members using the MCRP patient decontamination assemblage, AS 886A. Once trained, unless PCS'd, the Decontamination Team Chief and NCOIC will remain on the team for a minimum of two years; other team members will remain on the team for a minimum of one year. Replacement team chief and NCOIC personnel should attend the course before the incumbent leadership is relieved of this responsibility. **Note:** For team chiefs and NCOICs stationed at remote locations, attendance of the course is not required as long as they are trained locally by an individual who has attended the formal course. This training must occur within 30 days of assignment. If no formally trained individual is available, the team chief and NCOIC must attend the course.

7.2.1.5. An MOU will be established with local contractors, civil engineers, or other appropriate agency to dispose of hazardous waste, including water generated during patient decontamination.

7.2.2. **Nursing Services Team.** The Nursing Services team provides first aid and basic medical care to casualties following decontamination. The Nursing Services team chief is responsible for the maintenance and management of the 886D AS, which consists of first aid and medical supplies and is only assigned to medical units with an inpatient capability. Minimum training requirements for the Nursing Services Team are provided in Table 7.3.

Table 7.3. Minimum Training Requirements for the Nursing Services Team.

MCRP Team	Training Requirement	Frequency	Required for
Nursing Services (886D)	CBRNE EPRC	Initial and refresher every three years	Clinicians assigned to the team take the CBRNE EPRC Clinician/Provider Course; all others take the CBRNE EPRC Operator/Responder Course
	First Responder/Receiver Awareness Training	Initial and refresher every 12 months	All personnel assigned to the team

7.2.3. **Pharmacy Team.** The Pharmacy team serves as the pharmaceutical logistics and supply center for all CBRN related pharmaceuticals and will be the single point of contact for dispensing and ordering pharmaceuticals for all CBRN related needs. All MCRP teams, medical unit wards, clinics, points of dispensing (PODs), and installation medical responders will contact the pharmacy team for pharmaceutical needs. The pharmacy team chief is responsible for the maintenance and management of the 886E AS and SG06. Minimum training for the Pharmacy Team is provided in Table 7.4.

Table 7.4. Minimum Training Requirements for the Pharmacy Team.

MCRP Team	Training Requirement	Frequency	Required for
Pharmacy (886E)	CBRNE EPRC Operator/Responder Course	Initial and refresher every three years	All personnel assigned to the team
	First Responder/Receiver Awareness Training	Initial and refresher every 12 months	All personnel assigned to the team

7.2.3.1. The pharmacy team chief will develop a working plan to provide pharmaceuticals from the sub-assemblages to the appropriate MCRP teams when requested.

7.2.3.2. In the event of a CBRN incident, 886E AS pharmaceuticals will be exhausted first, followed by the peacetime operating stock, and finally WRM pharmaceuticals (if maintained by the unit). In the event the incident exhausts the local military installation supplies, pharmaceuticals may be available for CONUS units through the Strategic National Stockpile (SNS) activation.

7.2.3.3. The pharmacy team chief will also develop a mass prophylaxis (vaccination, medications, etc.) distribution plan based on credible threat or event, and ensure plan integration with the MCRP. Additionally, pharmacy team personnel will work with wing POCs to integration into the wing's Disease Containment Plan. The installation commander or higher authority will provide credible threat input based upon installation or event variances. Procedures must address how to access the SNS and receive and distribute pharmaceutical items. Team chiefs at installations outside the United States and its territories will coordinate through their respective MAJCOMs and host nations to determine an appropriate mass prophylaxis strategy.

7.2.4. **Bioenvironmental Engineering (BE) Team.** The BE team performs health risk assessments and recommend controls to Commanders through identification and analysis. BE team MC-CBRN support and responsibilities identified during pre-event planning operations, immediate emergency operations, sustained operations and recovery operations are supported by 886H AS (976H AS for ANG). The BE Team will provide direct on-scene involvement and interface with the Incident Commander (IC). Minimum training requirements for the BE team are provided in Table 7.5.

Table 7.5. Minimum Training Requirements for the BE Team.

MCRP Team	Training Requirement	Frequency	Required for
Bioenvironmental Engineering (886H)	HAPSITE basic training (CBT or in-residence course equivalent)	Initial Only	All personnel assigned to the team
	Respiratory Protection Training	Initial and refresher every 12 months	All personnel assigned to the team
	HAZMAT Operations Training	Refresher or demonstration of competency every 12 months	All personnel assigned to the team. Initial training is provided in AFSC awarding courses.
	BE Proficiency Verification – QUSI	Quarterly	For all personnel assigned to the team
	RSVP Training	Every 24 months	All personnel assigned to the team

7.2.4.1. PAT Proficiency Verification (QUSI): Personnel with unsatisfactory results will have 30 days from the original QUSI due date to obtain necessary in-house re-training and resubmit QUSI results. If second try is failed the individual will be deemed non-proficient on the piece of equipment and results will be forwarded to Flight/CC. Two consecutive non-proficiency ratings within a 12 month period will show an individual overdue on PATs. The results will be reflected accordingly in MRDSS ULTRA and reported to the appropriate MAJCOM BE.

7.2.4.2. The PAT Proficiency Verification -Electronic Education packets (E-PACs) program includes Electronic Education Packets (E-PACs) that are designed to be a group effort. Two E-PACs are required each quarter.

7.2.4.3. The BEE RSV Web Tool provides a standardized validation process for 886H equipment and software aids. The web tool does not replace lesson plans or training materials required for completion of RSVP training.

7.2.4.4. Bioenvironmental Engineering officers, enlisted, and equivalent civilian personnel will maintain HAZMAT Operations Training currency. The AF School of Aerospace Medicine Bioenvironmental Engineer Officer Course and the Bioenvironmental Engineer Apprentice Course satisfy the initial training requirements for HAZMAT Operations except for training objectives listed in Table 7.6. The BE office will conduct local HAZMAT training for their personnel and will include verification or certification of competency in these objectives.

Table 7.6. Local HAZMAT Training Objectives.

1.	The ability to realize the need for additional resources and to make appropriate notifications through the chain of command or incident command system (ICS), as described in local installation plans.
2.	An understanding of the relevant standard operating procedures and termination procedures as described in local installation plans.
3.	Understand how to implement the local installation emergency management plan.
4.	Understand how installation responders integrate with state and local response agencies and plans.

7.2.4.5. BE officers or civilian personnel who have not attended the AF School of Aerospace Medicine BEE Officer or Apprentice Course will receive HAZMAT Operations Training.

7.2.4.6. BE personnel will receive annual refresher training on assigned HAZMAT Operations emergency response duties. They may also demonstrate competency during exercises or actual responses. Refresher training certification via exercises or responses is only permitted when documentation by the BE team chief shows specific HAZMAT Operations Refresher training objectives were met. Refresher training is web-based and provided via MED LEARN.

7.2.5. **Laboratory Biological Detection Team (LBDT).** As a sub-element of the laboratory team, the LBDT has the capability to identify biological agents of operational concern in environmental and clinical samples using the Joint Biological Agent Identification Diagnostic System (JBAIDS) and M1M capabilities within the 886I AS. All medical unit laboratories with three or more personnel assigned (including civilians) will have an 886I AS and an LBDT. The LBDT will consist of no less than two members. The LBDT will participate in AF proficiency testing to maintain team skills. Minimum training requirements for the LBDT are provided in Table 7.7.

Table 7.7. Minimum Training Requirements for the LBDT.

MCRP Team	Training Requirement	Frequency	Required for
LBDT (886I)	JBAIDS Training	One time only	Two members of the team (same personnel require JBAIDS competency testing)
	JBAIDS Proficiency/Competency Testing	Every 12 months	Two members of the team (same personnel require JBAIDS training)
	M1M Training	One time only	Two members of the team (same members require M1M competency testing). Units not required to maintain M1M are not required to perform this training.
	M1M Proficiency/Competency Testing	Every 12 months	Two members of the team (same personnel require M1M training)
	CBRNE EPRC Operator/Responder Course	Initial and refresher every three years	All personnel assigned to the team
	First Responder/Receiver Awareness Training	Initial and refresher every 12 months	All personnel assigned to the team

7.2.5.1. All LBDT personnel must be enrolled in the Respiratory Protection Program and at least one team member must be immunized against smallpox.

7.2.5.2. The LBDT will have a facility outside or separate from the medical facility to prepare environmental samples for testing. The facility may be attached to the MTF as long as it has a separate entrance and separate heating, ventilation and air conditioning (HVAC). The facility must have two rooms to separate sample processing and polymerase chain reaction testing; otherwise, when performing polymerase chain reaction testing, the extracted nucleic acids can be brought into the medical facility's clinical lab for testing. The laboratory must have a policy in place to refer samples to a higher complexity laboratory for results confirmation, as required.

7.2.5.2.1. If the costs associated with maintaining a separate facility are unreasonably excessive, or if there are no alternate locations, this situation must be discussed in the MRC meeting to determine potential options. In these cases, the medical group commander may opt to bring properly prepared samples into the clinical laboratory for testing on the Joint Biological Agent Identification Diagnostic System (JBAIDS) and/or M1M analyzer. If the commander opts to do this, he or she must authorize it in writing and include a certification that a local risk evaluation has been completed by BE personnel and that smallpox or equine encephalitis are not involved.

7.2.5.2.2. A properly prepared environmental sample is a raw sample that has been processed by a qualified BE or equivalent personnel using approved techniques. This processing consists of: a) transferring the raw sample, after screening for explosives, volatile chemicals, and radiation, into a container holding a phosphate buffer solution or another approved transport medium and capping the container, b) performing

proper contamination avoidance procedures on the sample container (such as decontamination, double bagging, etc), and c) initiating proper chain of custody procedures which include documenting all contextual information such as results of field screening tests and purpose of requested lab analyses.

7.2.5.3. Units without the 886I AS, or with less than three assigned laboratory personnel, must still maintain the laboratory biological detection capability through an MOU/MOA/MAA, which must be tested annually.

7.2.6. **Field Response Team.** The MCRP teams formerly known as Aerospace Medicine Team and Field Treatment Team/Immediate Medical Response (IMR) have been combined to form the Field Response Team. This team provides the medical initial responders and any follow-on medical emergency responders to the scene as requested by the on-scene commander and is responsible for assessing the situation and requesting additional support as necessary. This team provides emergency stabilization, treatment, and preparation for transport of casualties, as well as direct on-scene involvement and interface with the IC. This team will coordinate with the Patient Administration team on the transport and tracking of patients transferred to other facilities. Supplies provided in 886J AS are used for the immediate medical CBRN response capability. The Field Response Team chief manages 886J AS and determines how the supplies will be packaged for response. Minimum training requirements for the Field Response Team are provided in Table 7.8.

Table 7.8. Minimum Training Requirements for the Field Response Team.

MCRP Team	Training Requirement	Frequency	Required for
Field Response (886J)	CBRNE EPRC	Initial and refresher every three years	Clinicians assigned to the team take the CBRNE EPRC Clinician/Provider Course; all others take the CBRNE EPRC Operator/Responder Course
	First Responder/Receiver Operations Training	Initial and refresher every 12 months	All personnel assigned to the team

7.2.7. **Triage Team.** A minimum of four personnel will be assigned to the Triage Team. The Primary Triage team consists of at least one provider (physician, dentist, PA or IDMT) and one nurse or medical technician tasked to triage patients arriving at the medical unit prior to decontamination. The Secondary Triage team will have a similar composition and provides triage after patient decontamination. If patient decontamination is not required, the teams function as one. Triage teams will use supplies in 886K AS (976K AS for ANG). Minimum training requirements for the Triage Team are provided in Table 7.9.

Table 7.9. Minimum Training Requirements for the Triage Team.

MCRP Team	Training Requirement	Frequency	Required for
Triage (886K)	Respiratory Protection Training	Initial and refresher every 12 months	All personnel assigned to the team
	First Responder/Receiver Operations Training	Initial and refresher every 12 months	All personnel assigned to the team
	CBRNE EPRC	Initial and refresher every three years	Clinicians assigned to the team take the CBRNE EPRC Clinician/Provider Course; all others take the CBRNE EPRC Operator/Responder Course

7.2.7.1. The Primary Triage team receives and triages casualties prior to decontamination. This includes all casualties whose contamination status is unknown and those who transport themselves. The Primary Triage team will don appropriate level PPE to establish a triage staging area outside the medical unit and in front of the patient decontamination entry point.

7.2.7.2. The Secondary Triage team performs triage/re-triage of decontaminated casualties as they enter the medical facility/single point of entry and should require PPE in accordance with universal precautions.

7.2.7.3. The ANG 976K AS is a small footprint, equipment only package that should be viewed as an SABC-plus capability. It is managed by any 4XXXX (not necessarily EMT trained) who is not assigned 976A AS, 976H AS or emergency operations center (EOC) responsibilities. Actual triage operations must be performed by medically trained and qualified personnel.

7.2.7.3.1. The 976K equipment set may be needed at the MDG, on-scene, or at some other pre-determined location on the installation. To accommodate this mobility the supplies/equipment from the 976K Allowance Standard will be packed in four response bags and stored with the 976A capability. Initial assessment and management of patients may be initiated by medically trained and qualified personnel and/or the responding ambulance service. The property custodian for 976K AS will be any 4XXXX (not necessarily EMT-trained) not already assigned patient decontamination (976A), BE (976H), or EOC responsibilities.

7.2.7.3.2. Upon activation, the triage team chief must work with the ICS response structure to ensure the adequate distribution of assets.

7.2.8. **Clinical Services Teams.** The Immediate, Delayed, and Minimal teams are responsible for emergency stabilization, treatment, and disposition of decontaminated and triaged victims in the emergency department or other treatment areas designated inside the medical unit and will utilize 886L AS. These teams will coordinate with the Patient Administration Team on the transport and tracking of patients transferred to other facilities. The Immediate Team chief is responsible for maintenance and management of the 886L AS and SG05. In facilities where there are limited physicians/providers, the MRC may designate a single Clinical Services Team. In that situation, the Clinical services Team Chief is

responsible for the 886L AS and SG05. Minimum training requirements for all Clinical Services Teams is provided in Table 7.10.

Table 7.10. Minimum Training Requirements for all Clinical Services Teams.

MCRP Team	Training Requirement	Frequency	Required for
Clinical Services (886L)	CBRNE EPRC	Initial and refresher every three years	Clinicians assigned to the teams take the CBRNE EPRC Clinician/Provider Course; all others take the CBRNE EPRC Operator/Responder Course
	First Responder/Receiver Awareness Training	Initial and refresher every 12 months	All personnel assigned to the team

7.2.9. **Manpower/Security Team(s).** Team responsibilities may be provided by two separate teams or one combined team. Individuals designated to support patient decontamination operations within the decontamination zone will be assigned to the Manpower/Security Decontamination Support Team, a sub-team of the Manpower/Security Team. Minimum training requirements for members assigned to either team are listed Table 7.11.

Table 7.11. Minimum Training Requirements for Manpower/Security Team Members.

MCRP Team	Training Requirement	Frequency	Required for
Manpower/Security Team (886M)	CBRNE EPRC Operator/Responder Course	Initial and refresher every three years	All personnel assigned to the team
	First Responder/Receiver Awareness Training	Initial and refresher every 12 months	All personnel assigned to the team
Manpower/Security Decontamination Support Team	Respiratory Protection Training	Initial and refresher every 12 months	All personnel assigned to the team
	First Responder/Receiver Operations Training	Initial and refresher every 12 months	All personnel assigned to the team

7.2.9.1. Security Team incident response includes door security during lock-down periods and perimeter security for the Decontamination and Primary Triage teams. During an incident involving CBRN agents, the Security team is responsible for restricting vehicular and pedestrian access to the medical unit campus in addition to securing the triage staging area outside the medical unit. The Security team will don appropriate level PPE when duties require presence in a contaminated environment. The Security Team Chief is responsible for maintenance and management of the 886M AS.

7.2.9.2. The Manpower Team augments other teams, provides patient transport, and performs other duties as directed by the MCC.

7.2.10. **Public Health Team.** The public health team provides biological subject matter expertise for the MTF.

7.2.10.1. Minimum training requirements for the Public Health Team are provided in Table 7.12.

Table 7.12. Minimum Training Requirements for the Public Health Team.

MCRP Team	Training Requirement	Frequency	Required for
Public Health (886P)	CBRNE EPRC Operator/Responder Course	Initial and refresher every three years	All personnel assigned to the teams
	First Responder/Receiver Awareness Training	Initial and refresher every 12 months	All personnel assigned to the team

7.2.10.2. The Public Health team is responsible for management of the 886P AS and performs the following:

7.2.10.2.1. Biological agent detection, in conjunction with other MCRP teams. Public health team biological agent detection capabilities include food borne agent detection, vector borne agent detection, medical intelligence, and communicable disease surveillance;

7.2.10.2.2. Biological agent response activities, to include epidemiological investigations, risk communication, disease containment planning and strategies, and local agency partnership leadership.

7.2.10.2.3. Active monitoring of Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE) in accordance with AF policy.

Chapter 8

BASE LEVEL EXERCISES

8.1. General. This chapter provides an overview of base-level exercise planning roles and responsibilities, to include roles and responsibilities, exercise types, requirements, and documentation. A full list of requirements is provided in Attachment 6.

8.2. Purpose of Exercises. Exercises are conducted to evaluate an organization's capability to execute one or more portions of its response or contingency plans. Exercises should be scenario-driven and be designed to validate procedures and improve processes outlined in plans and planning documents. Each exercise should provide a realistic rehearsal for installation medical response or deployment situations, and may be conducted in a tabletop, limited function, or full-scale format. Exercises may provide excellent training opportunities but should not replace established training programs.

8.3. Exercise Types. Exercises fall into one of three categories: tabletop or walkthrough exercises (TTX), limited scope exercises which include command post exercises (CPX), or full-scale field training exercises (FTX). The scope of the exercise varies widely from type to type. Exercise planners may blend exercise types (for example, a field exercise where aeromedical evacuation is managed as a functional exercise only) to achieve objectives. Review the exercise objectives carefully to determine the appropriate exercise method for the situation.

8.3.1. **Tabletop or Walkthrough Exercises (TTX).** A tabletop exercise is frequently used to test a new plan or procedure. It is designed to allow participants to examine and resolve problems in an informal, stress-free environment. The success of the exercise is largely determined by group participation and the identification of problem areas. These exercises are particularly effective if lead by an experienced facilitator. Tabletop exercises should be utilized judiciously. Follow the restrictions provided in AFI 10-2501.

8.3.2. **Command Post Exercises (CPX).** A CPX is generally sponsored by higher headquarters (wing, numbered AF, combatant command, MAJCOM) and includes primarily command and control functions.

8.3.3. **Field Training Exercise (FTX).** An FTX simulates a real event as closely as possible. To accomplish this realism, the exercise should include the mobilization and actual movement of personnel, equipment, and resources. FTXs are excellent evaluation and training tools, but they are often costly and time-consuming to plan and execute.

8.4. Exercise Evaluation Team. The relationship between the MR office and medical EET is a partnership. The medical planners in the MR office will assist the medical EET chief in planning exercises throughout the year to ensure aspects of medical plans and checklists are tested. The medical EET chief and other members of the EET will represent medical exercise requirements at wing exercise development meetings. Prior to meeting with the wing, the EET and MR office will meet to identify particular areas appropriate for testing in a specific exercise, incorporating open items in the MRC/EMC minutes from previous exercises. See Chapter 2 for additional EET responsibilities.

8.5. Exercise Design. Exercises should be designed to locate and eliminate problems in response and contingency plans before an event occurs. Additionally, exercises enable personnel to practice their roles and gain experience and confidence prior to an actual contingency situation.

8.5.1. **Exercise Objectives.** Well constructed exercises meet these objectives:

8.5.1.1. Test and evaluate plans, policies, and procedures

8.5.1.2. Reveal planning weaknesses

8.5.1.3. Reveal gaps in resources

8.5.1.4. Improve organizational coordination and communications

8.5.1.5. Clarify and practice roles and responsibilities

8.5.1.6. Improve individual and team performance

8.5.1.7. Demonstrate capabilities to associated organizations; gain support and develop teamwork

8.5.1.8. Build upon past lessons learned to establish competence in all contingency-related functions.

8.5.2. **Participants.** Exercise participants are determined by the size and scope of the exercise. A TTX might include only key decision makers, while an FTX can include all members of the organization, as well as supporting organizations and the community. Additionally, the exercise participants may include controllers, evaluators, observers, and simulated victims. The planner must ensure safety for all participants during the exercise, and should consider transportation, messing, billeting, and administrative support when required.

8.5.3. **Exercise Development and Planning Factors.** Various planning factors combine to establish an effective exercise program.

8.5.3.1. Realistic Scenarios. Exercises must be realistic and contingency based. Medical unit response and contingency deployment capabilities vary widely. Therefore, each MTF's exercise program must be tailored to their local capabilities on and off base, support/assistance agreements, local jurisdiction, other military unit capabilities, and contracts. Overseas locations must also consider host nation agreements, noncombatant evacuation operations, humanitarian operations, and other factors. Ensure established MOUs/MOAs/MAAs are adequately tested, including full participation of support agencies, as determined locally.

8.5.3.2. Threat Vulnerability. Exercise planners should accurately assess the threat vulnerability on base and in the community and design exercise objectives consistent with that threat, keeping in mind that documents referencing specific vulnerabilities may be classified.

8.5.3.3. Training. Exercise scenarios should maximize opportunities for training by appropriately incorporating team or individual participation and operational processes and procedures. Minimize simulations and assess actual abilities consistent with safety, exercise objectives, and real-world constraints. Exercise participants will access and use

the appropriate HSMR or WRM equipment based upon the exercise scenario and supplies will be used to provide a more realistic exercise. Supplies used during an exercise involving a response to a CBRN contingency or any CBRN Wing level exercise should be replenished using the MC-CBRN Program Funding LAF PE 28036F (PE 58036F for ANG). Seek reimbursed for WRM supplied used in accordance with AFI 41-209.

8.5.3.4. Assessing Capability. Include DRRS METs in exercise objectives and evaluation criteria to allow the unit to demonstrate proficiency. The commander will consider exercise results in his DRRS assessment.

8.5.3.5. Community/Base Participation. Test MOUs/MOAs/MAAs by inviting local community partners and on-base agencies to participate in the exercise, as appropriate. At a minimum, all agreements with local civilian medical and emergency response agencies must be reviewed annually. MC-CBRN response will be exercised annually. Participation will be documented in the Post-Incident/Exercise Summary (PIES) and copies provided to participating agencies.

8.5.3.6. Wing/Base Exercise Schedule and Availability. The medical unit should aggressively pursue opportunities to participate in wing exercises. However, if the wing fails to conduct all required exercises, the medical unit must conduct them independently. **EXCEPTION:** Exercises deemed not applicable to the base/wing (e.g. nuclear weapons exercise) will be considered not applicable to the medical unit as well.

8.5.4. Special Exercise Considerations.

8.5.4.1. LS MTFs, LSISS MTFs, and non-collocated ARC units must work with their wing/base/installation EET to determine the best way to conduct exercises required by other AFIs. MTFs will combine their exercises with sister service or wing/base/installation exercises to the greatest extent possible. Exercise scenarios must be developed collaboratively to test medical response capabilities as they would realistically be employed. In addition, the following AFI 41-106-driven exercise requirements must be conducted as follows:

8.5.4.1.1. MCOOP: one required annually, may be conducted as a TTX every other year; may be combined with a natural disaster, major accident, pandemic event or disease containment plan exercise.

8.5.4.1.2. Recalls: two unit-wide recalls required annually; one must be report-to-duty recall; one may be telephonic notification only.

8.5.4.1.3. LS MTFs, LSISS MTFs, and non-collocated ARC units that maintain MC-CBRN AS will also conduct one Disease Containment Plan (DCP) exercise and one terrorist use of CBRN exercise in accordance with Attachment 6. MTFs that do not maintain 886E and 886P can conduct the DCP exercise as a TTX.

8.5.4.1.4. The exercises listed above must be accomplished with or without base/installation participation or support.

8.5.4.2. LSISS MTFs will also meet host unit/service exercise requirements. If the unit is unable to combine their exercise requirements with those of the sister service, the unit must conduct their own exercises.

8.5.4.3. All exercises dictated by other AFIs must be accomplished in accordance with the established guidance or waivers sought through appropriate OPRs. However, if the base/installation does not conduct all exercises required by other AFIs, the MTF is not expected to conduct them on their own.

8.5.4.4. Deployed MTFs should participate, as mission requirements permit, in their host wing/base/installation's exercise program, especially major accident response. Deployed MTFs are not expected to plan or conduct large-scale exercises on their own; however, deployed MTFs must conduct a unit-wide recall, or personnel accountability exercise, every three months.

8.6. Required Exercises. Exercise requirements are generated by this Instruction and other directives including AFI 10-403, AFI 10-2501, AFI 10-2603, and AFI 10-2604. Non-medical exercise requirements may be met by participating in wing exercises. If so, there is no requirement to duplicate them in a medical personnel-only exercise. If the wing does not meet the exercise requirement, the MTF must be prepared to meet the requirement independently. Additionally, exercises approved by the Readiness Training Oversight Committee (RTOC) may serve as a vehicle for meeting these requirements. A full list of exercises is provided in Attachment 6. **Note:** For AFRC, exercises will be accomplished in accordance with applicable base plans.

8.6.1. **Medical Continuity of Operations (MCOOP).** The MTF's MCOOP must be exercised to identify patient staging, dispersion, and tracking processes and capabilities; communications; command and control procedures; and critical installation mission support. Include transportation, CE, and security forces requirements in MCOOP planning and exercises. The MCOOP exercise may be conducted as an annual TTX, however, actual relocation of the command and control function must take place every other year.

8.6.2. **Recalls**. Recall exercises demonstrate the unit's ability to return to duty in response to a contingency situation. Acceptable response standards are generally established by the wing. If no wing standard exists, the MRC must establish the standard and include it in Annex A of the MCRP. Conduct all recall types identified in Attachment 6 at least once annually. ARC will conduct one unit-wide recall annually. Deployed MTFs will conduct one unit-wide recall or personnel accountability exercise every three months.

8.6.3. **National Disaster Management System (NDMS) Exercise.** Any unit with a formal NDMS role must exercise its NDMS plan IAW DODD 6010.22; planned in Exercise Requirement Cycles. One Exercise Requirement Cycle is three calendar years. The requirement per cycle is one Field Training Exercise (FTX) and two Tabletop or Walkthrough Exercises. NDMS exercises may be conducted in conjunction with and/or incorporated into other exercises.

8.6.4. **Disease Containment Plan (DCP) Exercise.** AFI 10-2604 requires the Installation DCP to be exercised annually, which requires an Installation-wide exercise. MTFs must exercise the following components of the DCP (may occur independently or as a single DCP exercise):

8.6.4.1. Mass Prophylaxis Plan Exercise: Must test and evaluate the MTF's ability to stand-up a POD and distribute medical countermeasures. The number of exposed patients should be sufficient to test and stress the facility and its available resources. The

exercise must test the use of the 886E AS for initial response and should test expanded response capabilities such as requesting SNS or WRM assets. The mass prophylaxis plan exercise may also be conducted in conjunction with the CBRN exercise or a mass casualty exercise. **Note:** The Mass Prophylaxis Plan Exercise requirement only applies to MTFs which have an 886E AS.

8.6.4.2. Disease Containment Strategy Exercise: Must test and evaluate the MTF's ability to implement disease containment strategies in support of both mission sustainment and patient care requirements. The exercise must test restriction of movement measures (e.g. social distancing, isolation, or quarantine), the use of the 886P AS for conducting epidemiological investigations and the ability of the PHEO to support the installation commander in declaring a public health emergency.

8.6.5. **Major Accidents.** A major accident is an accident that warrants response by the installation Disaster Response Force, of which the medical first responders are a part. It differs from day-to-day emergencies and incidents that are handled routinely by base agencies. Major accidents frequently include a mass casualty event to which the MTF will respond. Reference AFI 10-2501for more information.

8.6.5.1. A mass casualty event may include varying numbers of casualties but in general, should include a sufficient number of casualties to test and stress the facility and its available resources. Medical unit participation in a mass casualty must be consistent with capabilities and responsibilities identified in wing plans and the MCRP, and must test and evaluate all MCRP teams.

8.6.5.2. If the wing exercise plan does not adequately test the unit's capabilities (for example, the exercise stops at the entrance to the medical facility), the MTF should develop internal scenarios to supplement or extend the exercise.

8.6.5.3. Mass casualty events may quickly overwhelm local community resources, forcing the military MTF to stabilize and stage casualties for several hours even if there is no emergency department. Consequently, all patients should not be automatically transferred to the local community during an exercise.

8.6.6. **Natural Disasters.** Natural disasters include all domestic emergencies except those created as a result of enemy attack or civil disturbance. The exercise scenario should be typical of the geographic area (hurricanes in Florida, tornadoes in Kansas, earthquake in California) and should include exercising NDMS FCC capability, when applicable. Reference AFI 10-2501 and AFI 10-229, *Responding to Severe Weather Events*, for more information.

8.6.7. **Terrorist Use of CBRN.** Response to a CBRN event requires many of the same response actions as other types of incidents; however, responders must also establish and maintain a chain of custody for evidence preservation as directed by the Incident Commander. Additionally, responders must be alert for physical indicators and other outward warning signs of additional CBRN events and the potential for secondary attack.

8.6.7.1. All MCRP teams in Table 7.1 must participate in a Terrorist Use of CBRNE exercise twice annually. The Disease Containment Plan exercise may count as one of the two Terrorist Use of CBRNE exercises.

8.6.7.2. AS training may be conducted in conjunction with this exercise, which will include an operational test of assigned equipment items and validate team member proficiency in using assigned materiel. Make-up exercises for team members unable to participate in the original exercise may be accomplished as a table top, ensuring exercise objectives are addressed and member is able to demonstrate competency in performing team functions.

8.6.7.3. Scenarios designed to evaluate medical CBRN response will involve wearing of Personal Protective Equipment (PPE) for those teams assigned protective suit ensembles and should be structured to meet first responder operations level training objectives. Reference OSHA Standard 29 CFR 1910.120 (q)(6), accessible at **http://www.osha.gov**/ . At least one exercise per year must include off-base response agency participation.

8.6.8. **Deployment Exercise.** Medical personnel must participate in wing Commander directed exercises that test the wing's ability to prepare and process personnel and equipment for deployment, in accordance with AFI 10-403 and the installation deployment plan.

8.6.8.1. For units that do not have a supporting wing deployment processing function, the deployment exercise requirement will be met by conducting a test of the unit's internal deployment functions. This includes Air Force Deployment Folder (AFDF) review, personal equipment review (bag drag), and transportation coordination for a minimum of 25% of the unit's assigned standard UTCs. Units that do not have assigned standard UTCs will process at least two individuals, with the goal of testing the deployment process itself.

8.6.8.2. Enabler UTCs assigned to medical units will participate in a deployment exercise at least annually, and will include an operational test of associated medical WRM if assigned.

8.6.8.3. Pilot units with personnel UTCs and associated WRM assemblages/equipment are encouraged to incorporate exercising with this equipment into deployment exercise scenarios.

8.6.9. **Operational Readiness Exercise (ORE).** Operational Readiness Exercises prepare forces for situations they may encounter in the deployed environment. They must reflect the most stringent CBRN threats the unit could face. See AFI 10-2501 for more information.

8.7. Exercise Credit. Units may take exercise credit for real world response of similar scope and magnitude to exercise intent. For example, a response to a bus accident with multiple casualties utilizing numerous MCRP teams may satisfy a major accident exercise requirement. The same post-event procedures, such as a post-incident hot wash, PIES discussed in paragraph 8.8, and MRC/EMC review/discussion must occur. Credit may be taken only when objectives are met for the specific exercise type or subsequent corrective action is successful.

8.8. Documentation. Required documentation will include:

8.8.1. **Post-Incident/Exercise Hot wash.** The individual who was in command of the medical response will conduct a hot wash immediately following the incident/exercise, or as soon thereafter as practical. Team chiefs, participating medical EET members, the MR office staff, and key players should attend. Use this session to provide cross-feed among

participants and identify key deficiencies, areas for improvement, and problems not noted by the base EET. Key items identified in the hot wash will be included in the PIES.

8.8.2. **Post-Incident/Exercise Summary (PIES).** The unit must generate a PIES for each exercise it participates in, regardless of which agency conducted the exercise. It is compiled by the MR office within 30 days of the event, with verbal and written input from team chiefs, observers and EET members, and is submitted to the unit's MRC/EMC for review at the next meeting. This summary documents the unit's participation in an actual or exercise event. It describes the scenario, exercise objectives, and whether or not they were met and addresses the effectiveness of associated MCRP annexes and team checklists. In addition, the PIES documents individual participation for appointed positions that require exercise participation. A sample PIES can be found in the AFI 41-106 Toolbox, located on the AF Medical Readiness CoP.

8.8.2.1. PIES will include the following information, as applicable to the exercise or incident:

8.8.2.1.1. Incident/Exercise Overview. Include the date(s) and location(s) as well as the number and types of casualties, type of incident/exercise from the list at Attachment 6, and a list of participating teams, organizations, and key individuals, as applicable.

8.8.2.1.2. Exercise Objectives. List objectives established for the exercise.

8.8.2.1.3. Exercise Results/Achievement of Objectives. This section should address how each participating MCRP team's involvement contributed to the achievement of the defined exercise objectives. Include Defense Readiness Reporting System (DRRS) Mission Essential Tasks (METs) tested as part of the exercise; the PIES will serve as supporting documentation for DRRS ESORTS reporting (see paragraph 2.1.21.4.).

8.8.2.1.4. Training accomplished. Include at a minimum, MCRP team and/or RSVP tasks accomplished.

8.8.2.1.5. Findings and Observations. Include both in-house items as well as medical unit items identified at the installation level.

8.8.2.1.6. Recommended Changes to Checklists and Plans. Identify required changes or updates to the MCRP or CEMP 10-2 (or equivalent for LSISS MTFs) and supporting checklists. An OPR and suspense for completion will be determined by the MRC/EMC and must be documented in the minutes.

8.8.2.1.7. Exercise Requirements Fulfilled. List the exercise requirements met by the event. This is particularly important when different exercise types are combined.

8.8.2.2. PIES will be reviewed by the MRC/EMC and attached to the meeting minutes. Identified findings, observations and areas of concern will be discussed, identified as open items, assigned OPRs, and tracked through the MRC/EMC until resolved. Areas of particular interest include effectiveness of planning guidance, training programs, and operational response. Resolution of exercise findings requires identification and implementation of corrective action, testing in a subsequent exercise, presentation, and discussion during the next MRC/EMC meeting, and closure in meeting minutes. Unit

commanders will elevate corrective actions beyond unit capabilities to the wing or MAJCOM as appropriate, using the AF-Joint Lessons Learned Information System (AF-JLLIS). See paragraph 9.3.1.2 for more information.

8.8.3. **After-Action Reports (AAR).** After-action reports are submitted after participation in MAJCOM-level or higher exercises. See Chapter 9 of this Instruction and AFI 10-204, *Readiness Exercises and After-Action Reporting Program*, for additional guidance.

Chapter 9

MEDICAL READINESS REPORTING

9.1. Operational Readiness Reports. Operational readiness reports provide higher headquarters and other interested organizations, up to and including the Office of the Secretary of Defense and National Command Authority, necessary information to make critical decisions with regard to deployments, manpower, and resource requirements. The first three reporting systems described below are populated and updated at the unit level each month, giving commanders the opportunity to assess and report their unit capabilities. The remaining reporting processes are accomplished as needed to relay vital information to higher headquarters before, during or after a deployment or major event, as directed in this Instruction and referenced governing directives.

9.1.1. **Global Status of Resources and Training System (GSORTS).** GSORTS, also known simply as SORTS, is a JCS owned system used to measure and report the status of a unit's resources and training readiness, measured against that which is required to undertake its expeditionary mission. The Air Force uses SORTS data to monitor unit readiness, determine budgetary allocations, answer congressional inquiries, analyze readiness trends, and support readiness decisions. Medical units report on personnel readiness/availability, training, and equipment and supplies (WRM) readiness in SORTS.

9.1.1.1. SORTS serves a threefold purpose: it provides data critical to crisis action planning, supports the deliberate planning process, and is used in assessing the ability to meet Title 10, USC, responsibilities to organize, train, and equip forces to support combatant commanders. SORTS provides a major indicator of a unit's readiness status but it is not designed to measure the unit's combat capability.

9.1.1.2. Overall guidance for preparing and submitting SORTS reports is provided in AFI 10- 201.

9.1.2. Defense Readiness Reporting System (DRRS) Enhanced Status of Resources and Training System (ESORTS).

9.1.2.1. DRRS ESORTS was designed to enhance the information currently provided in SORTS, focusing on force capabilities assessed against appropriate outcomes and process measures. It is a secure web-based information system describing the status of organizations that contribute to the war fighting system. It was built around METs, explicit measures of performance relative to assigned standards, resources, and force sustainment requirements. ESORTS contains all the basic resource information that underlies standard SORTS processes, with the major difference being that the resource information is automatically provided by authoritative databases. The METs published in the AF Universal Task List (AFUTL) and associated standards and conditions, are available to assist the commander in his unit capability assessment. DRRS is accessed through the PACOM secure website at: **http://www2.hq.pacom.smil.mil**.

9.1.2.2. Commander's Assessment. The unit commander is responsible for assessing the "mission ready" status of the unit and its assigned UTCs, teams, and individual personnel when formally requested and as a "situational awareness" component of command. The commander must ensure, either through readiness-sponsored training activities or through

equivalency credit, that training is conducted for all assigned missions. The commander's assessment must be a combination of objective data and subjective review of actual operational expertise. The relative importance of each is determined by the commander, with a constant mission focus, rather than on academic, square-by-square compliance. The commander should use all available resources, including consultation with the executive team and readiness office, and the results of METs tested during exercises, as documented in the PIES, in order to make the final mission capability assessment (reference paragraphs 2.1.21.4 and 8.8.2.1.3).

9.1.3. **AEF Reporting Tool (ART).** ART supplements SORTS data by providing commander assessed ratings for each individual UTC, versus the unit as a whole. It provides a picture of a specific UTC's ability to perform its mission as defined in the UTC MISCAP. ART provides the ability to evaluate individual UTCs prior to tasking them, enabling the AEF Center to select the UTC with the best capability to meet deployment taskings. ART also helps to forecast shortfalls or limitations, which allows for resolution before they become critical issues or impair AEF sourcing. Only D-coded UTCs are reported in ART.

9.1.3.1. This SIPRNET tool uses the same measured resource areas as SORTS, but enables commanders to report the ability of an individual UTC to perform its mission anywhere in the world at the time of the assessment.

9.1.3.2. Overall guidance on preparing and submitting ART reports is provided in AFI 10-244.

9.2. Medical Reporting of Readiness Capabilities.

9.2.1. **AD Reportable Training.** Only personnel assigned to deployable UTCs (D-Coded UTCs) are used to calculate training percentages for SORTS, ART, and DRRS. Specific training items that are considered reportable are identified in Table 9.1 below. This training will be included in SORTS T-level calculations and will be provided to the unit commander for consideration in ART and DRRS ESORTS readiness assessments. Although individual training listed below may be applicable to a broader range of UTCs or personnel, they are only reportable for personnel assigned to the UTCs identified below.

Table 9.1. AD Reportable Training.

SORTS TRSA field	Training Requirement	Reportable for
TRSA1	UTC Training: CCATT Initial Course	All personnel assigned to the following UTCs: FFCCE, FFCCN, FFCCT, and FFQE4.
	UTC Training: CCATT Advanced Course	All personnel assigned to UTCs FFCCE, FFCCN, FFCCT, and FFQE4.
	UTC Training: AECOT Course	All personnel assigned to UTCs FFVNM, FFVNP, FFCCE, FFCCN, and FFCCT.
	UTC Training: EMEDS Course	All personnel assigned to the following UTCs: FFDAB, FFMFS, FFEP1, FFEP2, FFEP3, FFEP6, FFF0C, FFPM1, FFPM2, FFPM3, and FFPCM.
	UTC Training: CASF Course	All personnel assigned to the following UTCs: FFVNF, FFVSF, and FFVCF.
	UTC Training: CPM Course	All personnel assigned to FFGRL
	UTC Training: Contingency Counter Terrorism Casualty Decon Course	Only team chief and NCOIC for FFGLB
TRSA2	Tier 2A, ES Proficiency Training: SABC Skills Training	All personnel assigned to standard deployable D-coded UTCs. See AFI 36-2201

Note: Reportable Medical Readiness Training information in Table 9.1 is intended solely for reporting purposes and does not represent total nor minimum training requirements for these personnel. Only credentialed providers will be assigned to standard UTCs and considered available for deployment in the SORTS P-level calculations.

9.2.1.1. Only personnel assigned to standard UTCs are used for SORTS T-level calculations. The lowest of the four TRSA field percentages will drive the overall SORTS T-level. Refer to AFI 10-201 for further guidance.

9.2.1.2. Personnel assigned to FFCCE, FFCCN, or FFCCT UTCs are not considered 100% UTC-trained until they complete AECOT and both CCATT courses. Personnel assigned to FFQE4 are not considered 100% trained until they complete both CCATT courses but they are not required to attend AECOT.

9.2.1.3. For ART reporting, UTC personnel must complete all the training listed in Table 9.1 to be considered trained.

9.2.2. ARC Reportable Training.

9.2.2.1. ANG Reportable Training. ANG units will report the items listed in Table 9.2 for SORTS using the **TRSA1** field only, in ART, and for Wing assessment in DRRS.

Only personnel assigned to the UTCs listed are used to calculate training percentages, unless directed otherwise by the NGB/SGX.

Table 9.2. ANG Reportable Training.

Training Requirement	Reportable for	Frequency
UTC Training: EMEDS Course	All personnel assigned to the following UTCs: FFDAB, FFEP1, FFEP2, FFEP3, FFEP6, FFF0C, FFPCM, FFPM1, FFPM2, FFPM3, FFMFS, and FFMRO.	IAW para 6.4.3.
UTC Training: C-STARS	Personnel listed on the C-STARS training matrix	IAW para 6.3.2.
UTC Training: CCATT Initial Course	All personnel assigned to the following UTCs: FFCCE, FFCCN, and FFCCT.	IAW para 6.4.7.
UTC Training: CCATT Advanced Course	All personnel assigned to UTCs FFCCE, FFCCN, and FFCCT.	IAW para 6.4.7.
UTC Training: AECOT Course	All personnel assigned to UTCs FFVNM, FFCCE, FFCCN, and FFCCT.	IAW para 6.4.5 and 6.4.7.

9.2.2.2. AFRES Reportable Training. AF reserve units will report the items listed in Table 9.3 for SORTS using the **TRSA1** field only, and in ART. Only personnel assigned to the UTCs listed are used to calculate training percentages, unless directed otherwise by AFRC/SGX. AFRES medical personnel are only considered trained if they maintain currency in both of the training requirements listed.

Table 9.3. AFRES Reportable Training.

Training Requirement	Course	Reportable for
UTC Training	CCATT Initial Course	All personnel assigned to the following UTCs: FFCCE, FFCCN, and FFCCT.
	CCATT Advanced Course	All personnel assigned to UTCs FFCCE and FFCCT.
	AECOT Course	All personnel assigned to UTCs FFVNM, FFCCE or FFCCT.
	EMEDS Course	All personnel assigned to the following UTCs: FFDAB, FFEP1, FFEP2, FFEP3, FFEP6, FFF0C, FFPM1, FFPM2, FFPM3, and FFMFS
	CASF Course	All personnel assigned to the following UTCs: FFVNF, FFVSF, and FFVCF.
Tier 2A, ES Proficiency Training	SABC Skills Training	All personnel assigned to standard deployable D-coded UTCs. See AFI 36-2201.

9.2.3. **Reporting MC-CBRN Capabilities.** Medical units possessing MC-CBRN assets (886 AS; 976 AS for ANG) will report their MC-CBRN capabilities to the installation's Emergency Management Working Group (EMWG) and Installation Readiness Council (IRC) through the MRC as described in paragraph 4.3.2.4 to allow installation commanders to make informed decisions and take appropriate actions to ensure installation CBRN response capabilities are maintained.

9.3. Reporting Lessons Learned.

9.3.1. **Reporting Methods.** To document operational and exercise observations, findings, and lessons learned, the AFMS utilizes three methods: the After Action Report (AAR), Air Force-Joint Lessons Learned Information System (AF-JLLIS), and the Post-Incident and Exercise Summary (PIES). Each one has specific uses and requirements.

9.3.1.1. After-Action Reports (AARs). AARs are formal documentation of a unit's participation in the CJCS Exercise Program, other joint exercises, Air Force level exercises, deployments for training (DFT), and real world operations including humanitarian, peacekeeping, and noncombatant evacuation operations (NEO). They are prepared for review principally outside the MTF, and are submitted in accordance with AFI 10-204.

9.3.1.1.1. Deployed commanders or UTC leaders should collect observations from team members during and following a deployment, consolidating them and preparing the AAR in accordance with AFI 10-204. UTCs with members from several units will submit a consolidated input, prepared by the senior member, in lieu of individual reports. In all cases, the report must be completed within 30 days of return from a deployment, contingency, or other operation, and the author must ensure the appropriate classification level is applied.

9.3.1.1.2. Following completion of the AAR, the author should review observations for the appropriate disposition method. Observations should be corrected at the lowest level possible which affords the appropriate outcome.

9.3.1.1.3. Major observations or lessons learned should be considered for their value for AF-JLLIS inclusion (see paragraph 9.3.1.2). Lessons learned that may impact units AF or DOD-wide, as well as ongoing issues regarding clinical care directives, including Joint Commission standards should be addressed in this manner. Each observation should follow the format prescribed on the AF-JLLIS input form.

9.3.1.1.4. Local unit issues such as individual qualifications, and issues which may be resolved internally by the MTF, should not be reported to AF-JLLIS. Instead, these issues should be highlighted for the MRC, assigned OPRs, and tracked in the MRC/EMC minutes until resolution.

9.3.1.2. AF-JLLIS. AF-JLLIS provides MAJCOM and AF-level documentation of individual observations and lessons learned resulting from a unit's participation in the CJCS Exercise Program, other joint exercises, Air Force exercises, and real world operations including contingency, humanitarian, peacekeeping, and noncombatant evacuation operations (NEO). Medical inputs to AF-JLLIS are prepared by medical personnel for review principally outside the medical unit, and are submitted in

accordance with AFI 90-1601, *Air Force Lessons Learned Program.* **Note:** Do not submit local action items as AF-JLLIS inputs.

9.3.1.2.1. Medical commanders must review AARs to ensure appropriate observations have been submitted to AF-JLLIS.

9.3.1.2.2. Higher-headquarters level reports may be submitted by MAJCOMs, Field Operating Agencies (FOAs), Direct Reporting Units (DRUs), and Headquarters Air Force (HAF) supporting agencies to AF JLLIS. HAF Lessons Learned personnel will forward these inputs to the AF/SG Lessons Learned (L2) points of contact for review and tracking.

9.3.1.2.3. Once AF/SG L2 points of contact receive an input from AF-JLLIS, they will coordinate with the appropriate AFMS consultants, MRAs, MAJCOMs, and other organizations to ensure the lessons learned are incorporated into doctrine and training as needed.

9.3.1.2.4. AF-JLLIS is provided in both a classified and unclassified version. Care should be taken not to include classified information in the unclassified version.

9.3.1.3. Post-Incident/Exercise Summary (PIES): The PIES is used to document the unit's participation in an actual or exercise event. It describes the scenario, exercise objectives, and whether or not they were met, DRRS METs evaluated, and any necessary updates or changes to associated MCRP annexes and team checklists. In addition, the PIES documents individual exercise participation for appointed positions that require it. See paragraph 8.8.2 of this Instruction for additional information on the PIES. Findings identified at the local level through local exercises, but requiring higher headquarters resolution, should be considered by the MRC/EMC for input into AF-JLLIS as described in paragraph 9.3.1.2 above.

9.4. Other Reports. Medical personnel often provide information on unit status, resource availability, and patient care activities during contingency operations (actual or exercise) in reports to higher headquarters. MTFs may also provide input to higher level situation reports in deployed or operational settings. See AFI 10-206 for a description of these reporting mechanisms and input requirements.

Chapter 10

AIR RESERVE COMPONENT GUIDANCE

10.1. General. This chapter provides guidance for ARC training, including Individual Mobilization Augmentees (IMA) and unit training; exercises; and additional requirements for AFRC and ANG medical units, including the CERFP.

10.2. Annual Tour Training Program. The purpose of the annual tour (AT) program is to provide Reserve medical personnel RSVP and upgrade training (UGT) in an MTF (AF, Army, Navy, or Joint), Veterans Affairs or civilian Level 1 Trauma Centers/Medical Centers/hospitals. Additional training requirements may also be met during AT such as UTC and theater specific training requirements, however, the primary purpose is to complete RSVP and UGT items that cannot be accomplished at the medical unit level. Additional information for planning an effective AT is provided in AFRCI 10-204, *Air Force Reserve Exercise and Deployment Program* and AFMAN 36-8001, *Reserve Personnel Participation and Training Program* and applicable MOU/MOA. In accordance with paragraph 2.1.16.8.4. ARC medical unit commanders may grant AT credit for deployment experience.

10.2.1. **Scheduling.** Active Component MTFs and AFRC/SG readiness personnel must negotiate training dates and expectations well in advance of the anticipated AT in accordance with the applicable MOU/MOA. ANG medical units will apply for overseas annual tour (OSAT) in accordance with the ANG Regional Training Cycle through NGB/SGXs Training and Tracking website. ANG units will not contact Active Duty host units without prior approval from NGB/SGX.

10.2.2. **Reserve Affairs Liaison.** Each Active Duty MTF will appoint in writing a Reserve Affairs Liaison and alternate to facilitate reserve training at their respective facility. The Reserve Affairs Liaison will:

10.2.2.1. Identify what training capabilities the facility can support and forward the information to HQ AFRC/SGX and National Guard Bureau (NGB) SGXT NLT 15 March of each calendar year to include preferred dates/time frames to schedule the ATs; maximum/minimum number of personnel they can support per group; number of tours that can be supported; AFSCs that can be supported as well as the maximum/minimum number of each AFSC; limitations such as training, billeting, transportation, messing, etc.

10.2.2.2. Ensure that IMA reservists receive required expeditionary medical operations training.

10.2.2.3. Provide to the IMA a copy of the MRTES to facilitate scheduling.

10.2.2.4. Notify RMG DET 15 of an IMA reservist who fails to comply with training requirements.

10.2.3. **Annual Tour (AT) Monitor.** Each ARC medical unit will appoint in writing an AT Monitor and alternate. One of the monitors will be an Air Reserve Technician (ART). The AT Monitor will:

10.2.3.1. Establish contact with the Reserve Affairs Liaison once notified by the AFRC/SG or NGB/SG of the approved AT to negotiate AFSC mix, dates, capabilities, etc.

10.2.3.2. Prepare and distribute training plans (T-Plans) 90 days before tour start date to host facility, applicable NAF/SG and HQ AFRC/SGX.

10.2.3.3. Forward credentials of health care providers, as defined in AFI 44-119, *Medical Quality Operations*, to host facility no later than 60 days prior to start date of tour or in accordance with MAJCOM or MTF guidance. Unit AT Monitor will request host facility credentials committee special requirements.

10.2.3.4. Prepare and distribute electronic copies of AT AARs to the host facility and HQ AFRC/SGX or NGB SGXT NLT 30 days after end of tour.

10.2.3.5. Failure to follow the established timelines could result in the cancellation of the AT.

10.3. Air Force Reserve Command (AFRC) Guidance. The following specific guidance is provided specifically for AFRC units, in addition to guidance provided elsewhere in this Instruction. See paragraph 9.3 for AFRC reportable training. In addition to those roles and responsibilities listed in Chapter 2, the AFRC Medical Unit Commander will:

10.3.1. **Oversight.** Designate either the EMC or the Education and Training Committee (E&TC) as the primary oversight of the medical readiness training function. This oversight is necessary to ensure medical readiness training requirements are scheduled based on the 24-month AEF schedule, to comply with applicable directives, and is included in the unit's annual training plan. If the E&TC is designated to provide oversight, they will forward to the EMC any issues requiring input or resolution from a higher authority.

10.3.2. **MRO/MRNCO.** Appoint an MRO and MRNCO in writing. The appointment letter should include assignment as the certification official for medical readiness training (excluding RSVP training). To maintain program continuity, personnel will remain in their position for a minimum of 24 months. Every effort will be made to avoid assigning additional duties, such as security manager, building custodian, etc., to the MR office staff.

10.3.3. **Exercise Evaluation Team (EET).** Appoint a medical EET Chief and representatives to the wing EET in writing, in accordance with local requirements. The MRO/MRNCO will not be the sole medical EET members. The medical readiness staff will identify exercise goals and objectives to the EET Chief who develops the scenario, executes the exercise, and evaluates results in order to fully test medical readiness and fulfill exercise requirements as outlined in this Instruction.

10.4. Individual Mobilization Augmentee (IMA) Program Management. Active Duty MTFs of attachment are responsible for providing training to their attached IMAs. The IMAs point of contact in the unit is the Reserve Liaison Officer/NCO or civilian manager.

10.4.1. **AFRC Unit MR Office.** This office will:

10.4.1.1. Obtain a list of attached IMAs at least annually from the unit Reserve Affairs Liaison.

10.4.1.2. Ensure all pertinent training is tracked in MRDSS ULTRA.

10.4.1.3. Forward training statistics to RMG DET 15, as required.

10.4.2. **IMA reservists.** These individuals will:

10.4.2.1. Plan for required MR training and complete training as required. Medical reservists in non-pay participating individual ready status are not required to complete training unless identified for deployment, at which time they will receive training on a just-in-time (JIT) basis.

10.4.2.2. Request orders using the Air Force Reserve Order Writing System (AROWS-R) if attendance will be in AT or Special Tour status and must be received at least 30 days in advance of scheduled training.

10.4.2.3. Medical IMA reservists may complete training requirements in one of three capacities.

10.4.2.3.1. Annual tour.

10.4.2.3.2. Inactive Duty Training (IDT). IDT status can include either pay or non-pay (retirement points only) status.

10.4.2.3.3. Special tour-Reserve Personnel Appropriation (RPA) man days. IMAs must request orders using AROWS-R 30 days in advance of scheduled training.

10.4.2.3.4. Active Duty units are responsible for tracking, providing, and documenting training to their assigned and attached IMAs.

10.5. Air Force Reserve Medical Counter-CBRN Program. The following guidance applies only to non-collocated AFRC units that maintain the MC-CBRN Bioenvironmental Engineering (886H) assemblage.

10.5.1. **Asset Management.** The 886 AS for the non-collocated AFRC units will be maintained in DMLSS by host MTFs as described in established medical logistics support MOUs and in AFI 41-209.

10.5.1.1. The host MTF is responsible for establishing the account, ordering supplies and equipment, inputting receivables, and documenting inventory results in DMLSS.

10.5.1.2. The supported unit will appoint a unit property custodian (normally BE personnel assigned to LAF units) for the assemblage. The property custodian will ensure required inventories are conducted and forward inventory data to the host unit within 30 days of completion. The property custodian will be granted access to MRDSS ULTRA for assemblage oversight and management purposes.

10.5.1.3. See AFI 41-209 for additional asset management guidance.

10.5.2. **Funding.** Funding for AFRC 886H equipment/supplies and training is provided through PE 52574F.

10.5.3. **Training.** Ensure personnel assigned to the MC-CBRN (886H) response team are trained. For AFRC units, this responsibility falls with the full time Bioenvironmental Engineering office, who accomplishes the duties listed in paragraph 2.1.19. Reference AFTTP 3-42.32, *Home Station Medical Response to CBRNE* for specific MC-CBRN requirements and resources for obtaining training.

10.5.3.1. At AFRC non-collocated bases, BE civilians will accomplish Disaster/Emergency Response training based on command guidance and execution of AFTTP 3-42.32 for the 886H AS. Minimum training will include those items listed in Table 10.1.

Table 10.1. Minimum Training Requirements for AFRC BE Personnel.

Disaster Response Team	Training Requirement	Frequency	Reportable for
Bioenvironmental Engineering (886H)	Disaster/Emergency Response Training [1]	At least quarterly	All personnel assigned to BE
	HAPSITE training (CBT or in-residence course equivalent)	Initial only	All personnel assigned to BE
	Respiratory Protection & Fit Testing	Initial and every 12 months	All personnel assigned to BE
	First Responder/Receiver Operations Training [2]	Initial and refresher every 12 months	All personnel assigned to BE
	BE Proficiency Verification – E-PACs	Monthly	All personnel assigned to BE
	BE Proficiency Verification – QUSI	Quarterly	All personnel assigned to BE
	RSVP Training	Every 24 months	All personnel assigned to BE

Note 1: Disaster/Emergency Response training shall use the most current checklists available – which should be tailored to fit local conditions. HQ AFRC/SGPB will provide examples.

Note 2: Team members who have completed First Responder/Receiver Operations Training are given credit for First Responder Awareness training. See para 6.5.1.1 for training access.

10.5.3.2. RSVP requirements include: equipment proficiency (HAPSITE, e-PAC program and QUSI, equipment manuals, etc.), PPE qualification, RSV web based tool completion, and performing health risk assessments (recognize, evaluate, control). In addition, AFRC BE personnel will complete the AERO introduction (as listed in AFI 10-2501, paragraph 6.6.5.1) course and participate in two Terrorist Use of CBRN Exercises annually.

10.5.3.3. All individuals in the AFRC civilian BE/PH office (for bases with the 886H AS) will be trained to respond using the 886H AS following Chapter 16 of AFTTP 3-42-32 (Aug 09). The response force may consist of a combination of BE, public health, civil engineers, or other designated personnel.

10.5.3.4. Individuals identified for response will also be trained to perform health risk assessments and to enter the warm/hot zone using Self-contained Breathing Apparatus (SCBA).

10.5.3.5. MC-CBRN training will be tracked by the MR office in MRDSS ULTRA.

10.5.4. **MC-CBRN Response Capabilities.** Minimum AFRC non-collocated unit MC-CBRN response capabilities will include:

10.5.4.1. Providing the commander adequate information to make decisions; initial identification and basic assessment only. MOUs/MOAs/MAAs with the local community will provide additional capability. A 4A0X1 can be utilized for logging in EPD data, entering info in medical records.

10.5.4.2. Responsibilities for biological samples will be to collect, package, ensure chain-of-custody, and transport.

10.6. Air National Guard Guidance. The following specific guidance is provided specifically for ANG units, in addition to guidance provided elsewhere in this Instruction.

10.6.1. **ANG Roles and Responsibilities.**

10.6.1.1. The NGB/SG, in addition to those roles and responsibilities listed in Chapter 2, will provide guidance to State Air Surgeons, State Joint Staffs, and the senior full-time medical person, and plan/program for any additional training these individuals may require.

10.6.1.1.1. Identify regional Lead State Air Surgeons and planners. Plan/program for any additional training these individuals may require.

10.6.1.1.2. May grant State Air Surgeons specific authority to implement/oversee specific areas of these or other responsibilities found in this Instruction.

10.6.1.2. The State Air Surgeon in states that have a directed DSCA mission, such as CERFP/HRF, ensure that all individual, team and collective training requirements are included in the master training calendar for each ANG medical unit in their state.

10.6.1.3. The ANG Medical Unit Commander, in addition to those roles and responsibilities listed in paragraph 2.1.16 will:

10.6.1.3.1. Designate either the EMC or the E&TC as the primary oversight of the medical readiness training function. The designated committee will ensure training requirements are based on the 24-month AEF schedule, as developed by the Strategic Planning Committee and included into the unit's annual training plan portion of the MRTES, and will comply with applicable directives. The oversight body will review training currency statistics and adjust training schedules as needed in order to maintain mission capable rates. If the E&TC is designated to provide this oversight, they will forward to the EMC or organization commander any issues requiring input/resolution from a higher authority. All requests for training waivers must first

be reviewed and approved (in writing) by the EMC or medical group commander prior to NGB/SGX final review.

10.6.1.3.2. Appoint, in writing, a MRO/MRNCO. The appointment letter will include assignment as the certification official for medical readiness training (excluding RSVP training).

10.6.1.3.3. For states that have a directed DSCA mission (CERFP/HRF), ensure that all individual, team, and collective training requirements are included in the master training calendar.

10.6.1.3.4. Appoint an EET Chief to serve as the unit exercise planner. Upon appointment, forward their name and contact information to NGB/SG.

10.6.1.4. ANG EMEDS commanders, who have not already attended, will apply to attend the Joint Operations Medical Management Course (JOMMC) immediately upon assignment to the position.

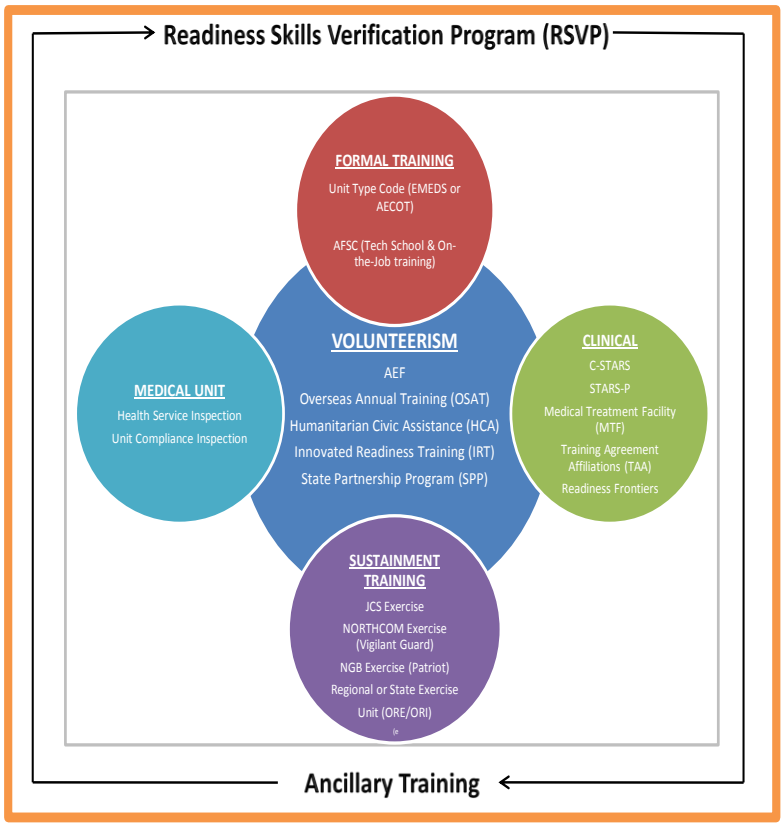
10.6.1.5. The MRO/MRNCO, in addition to the roles and responsibilities listed in Chapter 2, will ensure required material is provided to the EMC/E&TC at least quarterly.

10.6.2. **Executive Management Committee/Education & Training Committee (EMC/E&TC).** Document in either EMC or E&TC minutes the unit review of MR training data and ensure discrepancies are addressed with resolution action including appropriate get-well dates (GWD).

10.6.3. **Training.**

10.6.3.1. NGB/SG recommends the MR Training Cycle provided in Figure 10.1 as a methodology for completing all MR training requirements identified in this Instruction in a timely manner. Each circle represents one year in the training cycle. Units should adjust this schedule as necessary to incorporate Wing and additional unit training requirements. **Note:** The AEF/HCA/IRT/OSAT volunteer opportunities should be incorporated into established training cycles as time permits.

Figure 10.1. Sample ANG Training Cycle.



Note: Sustainment training is accomplished in accordance with the guidance in chapter 6 of this Instruction and includes MRA pre-approval of exercises to be used for sustainment training purposes.

10.6.3.2. ANG personnel assigned to the MASF UTC FFVNM will complete training in accordance with paragraph 6.4.5.

10.6.3.3. ANG personnel assigned to UTCs FFCCU, FFDAB, FFMFS, FFEP1, FFEP5, FFGKN, FFGKT, will complete C-STARS within 90 days prior to deployment. ANG personnel assigned to FFCCE and FFCCT will follow the guidance in paragraph 6.4.7.

10.6.3.4. ANG personnel assigned to EMEDS UTCs and any personnel identified for deployment in support of OCO will attend the EMEDS course and complete sustainment training IAW paragraph 6.4.3.

10.6.3.5. ANG Emergency Response Teams (ERT) may receive training credit during their respective regional exercise. Regional planners and State Air Surgeons are required to ensure regional exercise schedules and scenarios address NGB/SG identified training for these teams. ERTs will develop and maintain Post-incident/exercise summaries (PIES) that reflect training goals and achievement of those goals. Individual training accomplishments will be documented in MRDSS ULTRA.

10.6.3.6. MC-CBRN training for personnel assigned to support patient decontamination or BE response operations will be accomplished in accordance with Table 10.3 of this Instruction.

10.6.3.7. ANG units will use MRDSS ULTRA to document all MR training.

10.6.4. **Air National Guard Medical Counter-CBRN Program.** The following guidance applies to ANG units that maintain the MC-CBRN response assets (976 AS) listed in Table 10.1. These units will:

10.6.4.1. Manage the AS in accordance with AFI 41-209.

10.6.4.2. Plan to provide a small footprint, equipment only package necessary for stabilization and preparation for transport to definitive care facility for up to 100 patients for 24 hours, or until assistance is provided. Actual triage operations must be performed by medically trained and qualified personnel. Planning will include a collaborative community or unified response, including necessary support from other military or civilian agencies through the use of MOU/MOA/MAA, as appropriate. Planning must include the unification process, development of site medical command and control, and plan for the transfer of patient treatment to an off-installation facility (e.g. community healthcare facility).

Table 10.2. ANG MC-CBRN Response Assets.

ALLOWANCE STANDARD	RESPONSE TEAM	COMPOSITION	REFERENCE
976A, Patient Decontamination	Patient Decontamination Team	12 members, any specialty	Paragraph 7.2.1.
976H, Bioenvironmental Engineering	BE Team	2 BE personnel	Paragraph 7.2.4.
976K, Triage	Triage Equipment	None	Paragraph 7.2.7.3.

10.6.4.3. Ensure personnel assigned to MC-CBRN response teams are trained. For ANG units, this responsibility falls with the BEE, who will also accomplish the duties listed in paragraph 2.1.19. Reference AFTTP 3-42.32 for specific MC-CBRN requirements and resources for obtaining training. Table 10.3 lists MC-CBRN training requirements for the teams listed.

10.6.4.4. Utilize LAF PE 28036F/58036F to fund the ANG MC-CBRN Program.

Table 10.3. Minimum Training Requirements for ANG MC-CBRN Teams.

MC-CBRN Team	Training Requirement	Frequency	Reportable for
Bioenvironmental Engineering (976H)	HAPSITE training (CBT or in-residence course equivalent)	Initial Only	All personnel assigned to BE
	Respiratory Protection & Fit Testing	Every 12 months	All personnel assigned to BE
	Proficiency Analytical Testing (PAT) Proficiency Verification – BE	Quarterly	All three requirements (two monthly E-Pacs and one quarterly QUSI sample) for all personnel assigned to BE
Patient Decontamination (976A)	Patient Decontamination Course	One-time only	Patient Decontamination team chief and NCOIC
	Respiratory Protection & Fit Testing	Every 12 months	All personnel assigned to Pt. Decon.
	First Responder/Receiver Operations Training [1]	Initial and refresher every 12 months	All personnel assigned to Pt. Decon.

Note 1: Team members completing First Responder/Receiver Operations Training are given credit for First Responder Awareness training. See para 6.5.1.1 for training access.

10.7. ANG Chemical Biological Radiological Nuclear and High Yield Explosive Enhanced Response Force Packages (CERFP) and the Homeland Response Force (HRF). CERFP is a validated program with an approved mission. CJCS validated CERFP as a joint capability and the mission has been funded through the Program Objective Memorandum (POM). It is a directed mission that provides CBRNE consequence management to the civilian incident command system. The medical component of the HRF provides the same level of support as the CERFP. The mission should be validated in the near future. All future references in this Instruction will include both the CERFP and the HRF mission.

10.7.1. **Mission.** The CERFP/HRF responds to CBRNE incidents, natural disasters, or other catastrophic events and assists local, state, and federal agencies in conducting consequence management by conducting patient decontamination, emergency medical services, and casualty search and extraction.

10.7.2. **Guidance.** Guidance for the CERFP/HRF mission can be found in ANGI 10-2504. This regulation prescribes policies, procedures, and responsibilities governing the deployment and employment of CERFP/HRF in support of the National Guard Homeland Security mission.

10.7.3. **Medical Responsibility.** The medical element of the CERFP/HRF provides short duration, pre-hospital emergency medical treatment during response operations. Specifically, the medical team works with the casualty search and extraction teams to provide emergency medical triage and treatment in a contaminated and/or collapsed structure environment, to

ensure casualty stabilization and initial treatment prior to evacuation to a hospital for more definitive care.

10.7.4. **Planning Scenarios.** The CERFP/HRF medical element is foundationally developed upon EMEDS organizational, planning, staffing, training, and exercising tenets and requirements. As such, the medical unit of the CERFP may be modularly adapted to meet individual disaster response requirements, with both personnel and equipment easily tailored to specific circumstances, including those represented by the 15 Department of Homeland Security (DHS) disaster scenarios and captured in the 8 FEMA planning scenario sets, which can be found in the National Response Framework at: **http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf**. CERFP medical element leaders must consider these scenarios when developing unit plans.

10.7.5. **Leadership.** The medical element leader reports directly to the CERFP/HRF Commander or the Joint Task Force (JTF)-State Commander and is responsible for supervising the medical component of the CERFP/HRF. In addition, the medical element leader will:

10.7.5.1. Develop a plan to support the incident commander's incident action plan.

10.7.5.2. Coordinate medical CERFP/HRF activities.

10.7.5.3. Ensure organizational and logistics needs are identified

10.7.5.4. Receive and provide situation reports and records.

10.7.6. **Support.** The CERFP/HRF medical element has no indigenous operating support. Prior to deployment, operating support to include personnel housing and messing, water, electrical power (besides limited generator capability) and fuel, laundry facilities, and vehicles must be addressed.

10.7.7. **Planning.** The CERFP/HRFs ability to deploy within 6 hours creates an environment that requires extensive pre-planning and pre-coordination. Planning considerations include:

10.7.7.1. Ground or Airlift transportation

10.7.7.2. Deploying entire CERFP capability versus modular capability

10.7.7.3. CERFP operating support requirements

10.7.7.4. Fuel

10.7.7.5. Site selection and risk considerations

10.7.8. Training and Exercises. The CERFP/HRF mission requires members to be immediately deployable. Therefore, all required training must be accomplished in advance. CERFP/HRF training requirements are listed in Attachment 3, Table A3.4. See also the CERFP Joint training Plan (JTP) for additional training requirements.

10.7.8.1. All individual, team and collective training requirements are included in the unit's master training calendar.

10.7.8.2. Training scenarios should be developed to provide AFSC specific training, including RSVP, with emphasis on disaster scenarios most likely to elicit a CERFP/HRF deployment. Scenarios should also address varying risks from one state to another.

10.7.8.3. Each CERFP team is required to participate in one collective event (defined as all CERFP elements participating in a 3 to 6 day exercise) annually. These exercises should be designed to evaluate the CERFP team's ability to deploy, operate, and re-deploy in support of civilian authorities. Lessons learned from the exercises should be captured in a PIES and used in future planning efforts to ensure deficiencies are corrected.

CHARLES B. GREEN
Lieutenant General, USAF, MC, CFS
Surgeon General

ATTACHMENT 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

This attachment is intended as a quick-reference tool and contains publications, acronyms and terms that are referenced in this Instruction. .

References

DODD 1322.18, *Military Training, January 13, 2009*

DODD 3025.1, *Military Support to Civil Authorities, January 15, 1993*

DODD 6000.12, *Health Service Operations and Readiness, April 29, 1996*

DODD 6010.22, *National Disaster Medical System, January 21, 2003*

DODD 6490.02E, *Comprehensive Health Surveillance, October 21, 2004,*

DODD 6490.5, *Combat Stress Control Programs, February 23, 1999*

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None

Abbreviations and Acronyms

AAMI—Association for the Advancement of Medical Instrumentation

AAR—After-Action Report

AC—Active Component

ACC—Air Combat Command

ACLS—Advanced Cardiac Life Support

AD—Active Duty

ADCON—Administrative Control

ADLS—Advanced Distributed Learning Service

AE—Aeromedical Evacuation

AECOT—Aeromedical Evacuation Contingency Operations Training

AEF—Air and Space Expeditionary Force

AEFC—AEF Center

AERO—Air Force Emergency Response Operations

AETC—Air Education and Training Command

AF—JLLIS – Air Force-Joint Lessons Learned Information System

AFCAT—Air Force Catalog

AFCENT—Air Forces Central

AFDD—Air Force Doctrine Document

AFDF—Air Force Deployment Folder; replaced Personnel Readiness Folder

AFEMSI—Air Force Expeditionary Medical Skills Institute

AFFOR—Air Force Forces

AFI—Air Force Instruction

AFIA—Air Force Inspection Agency

AFIMS—Air Force Incident Management System

AFMAN—Air Force Manual

AFML—Air Force Medical Logistics

AFMLO—Air Force Medical Logistics Office

AFMOA—Air Force Medical Operations Agency

AFMSA—Air Force Medical Support Agency

AFMS—Air Force Medical Service

AFPC—Air Force Personnel Center

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AFRIMS—AF Records Information Management System

AFSC—Air Force Specialty Code

AFTH—Air Force Theater Hospital

AFTR—Air Force Training Record

AFTTP—Air Force Tactics, Techniques and Procedures

AFUTL—Air Force Universal Task List

AHLTA—T – Armed Forces Health Longitudinal Technology Application - Theater

AHRT—All-Hazards Response Training

AOR—Area of Responsibility

ARC—Air Reserve Component (includes Air National Guard and Air Force Reserve Command)

AROWS—R - Air Force Reserve Order Writing System

ART—AEF Reporting Tool; also Air Reserve Technician

AS—Allowance Standard

ASIMS—Aeromedical Services Information Management System

AT—Annual Training; also Annual Tour (ARC)

ATLS—Advanced Trauma Life Support

AWS—Associated But Available To Support MTW and Steady State

AWX—Associated but Available To Support MTW But Not Steady State

AXS—Associated But Available To Support Steady State but Not MTW

AXX—Associated and Required In-Place and Not Available For MTW or Steady State

BBP—Bloodborne Pathogens

BCA—Business Case Analysis

BEE—Bioenvironmental Engineer

BEMRT—Basic Expeditionary Medical Readiness Training

BETM—Base Education Training Manager

BLS—Basic Life Support

BOS—Base Operating Support

BP—Building Partnerships

BPC—Building Partnership Capacity

BSP—Base Support Plan

BW—Biological Warfare

C2—Command and Control

C4—Combat Casualty Care Course

C4I—Command, Control, Communications, Computers and Information

CAF—Combat Air Forces

CAFSC—Control AFSC

CASF—Contingency Aeromedical Staging Facility

CBD—Consultant Balanced Deployments

CBRN—Chemical, Biological, Radiological and Nuclear

CBRNE—Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive

CBT—Computer-based Training

CC—Commander

CCB—Configuration Control Board

CDC—Centers for Disease Control

CDM—Constant Deployer Model

CCATT—Critical Care Air Transport Team

CCDR—Combatant Commander

CCLM—Center for Clinical Laboratory Medicine

CCMRF—CBRN Consequence Management Response Force

CDM—Constant Deployer Model

CE—Civil Engineering

CEMP—Comprehensive Emergency Management Plan

CERFP—ANG Chemical Biological Radiological Nuclear and High Yield Explosive Enhanced Response Force Packages

CFM—Career Field Manager

CMCC—CBRNE Medical Casualty Course (ANG CMCC)

CME—Continuing Medical Education

CONOPS—Concept of Operations

CONUS—Continental United States

COOP—Continuity of Operations

CoP—Community of Practice

COT—Commissioned Officer Training

CPG—Computerized Practice Guidelines

CPM—Contingency Preventive Medicine

CPS—Consolidated Planning Schedule

CPX—Command Post Exercise

CRG—Contingency Response Group

CSC—Combat Stress Control

CSDC—Consolidated Storage and Deployment Center

CSS—Commander's Support Staff; also Commander's Senior Staff; also Central Sterile Supply

C-STARS—Centers for Sustainment of Trauma and Readiness Skills

CT—Computed Tomography

CW—Chemical Warfare

DAFSC—Duty Air Force Specialty Code

DAV—Deployment Availability

DCP—Disease Containment Plan

DFT—Deployment for Training

DHP—Defense Health Programs

DHS—Department of Homeland Security

DMLSS—Defense Medical Logistics Standards Support

DNIF—Duty Not Involving/Including Flying

DOC—Designed Operational Capability

DOS—Department of State; also Date of Separation

DRF—Disaster Response Force

DRRS—Defense Readiness Reporting System

DRU—Direct Reporting Unit

DSCA—Defense Support to Civil Authorities

DU—Depleted Uranium

DWS—Deployable and Available To Support MTW and Steady State

DWX—Deployable and Available To Support MTW but Not Steady State

DXS—Deployable and Available To Support Steady State but Not MTW

DXX—Deployable But Required In Place and Not Available For MTW or Steady State

E&T—Education and Training

E&TC—Education and Training Committee

ECD—Estimated Completion Date

ECS—Expeditionary Combat Support

EET—Exercise Evaluation Team

EKG—Electrocardiogram

EM—Emergency Management

EMC—Executive Management Committee

EMDG—Expeditionary Medical Group

EMEDS—Expeditionary Medical Support

EMRC—Expeditionary Medical Readiness Course

EOC—Emergency Operations Center

EPRC—Emergency Preparedness and Response Course

ERT—Emergency Response Team

EST—Expeditionary Skills Training

ESF—Emergency Support Function

ESORTS—Enhanced Status of Resources and Training System

ESP—Expeditionary Site Plan

ESSENCE—Electronic Surveillance System for Early Notification of Community-based Epidemics

EXORD—Execution Order

FAM—Functional Area Manager

FCC—Federal Coordinating Center

FEMA—Federal Emergency Management Agency

FMC—Fully Mission Capable

FOA—Forward Operating Area; also Field Operating Agency

FOUO—For Official Use Only

FS—Flight Surgeon

FTX—Field Training Exercise

GSORTS—Global Status of Readiness and Training System

GSU—Geographically Separated Unit

GWD—Get-well Date

HA/DR—Humanitarian Assistance & Disaster Relief

HAF—Headquarters Air Force

HARM—Host Aviation Resource Management

HAZMAT—Hazardous Material

HICPAC—Healthcare Infection Control Practices Advisory Committee

HCW—Health Care Worker

HRC—High Risk of Capture

HRF—Homeland Response Force

HSI—Health Services Inspection

HSMR—Home Station Medical Response

HSPD—Homeland Security Presidential Directive

HVAC—Heating, Ventilation and Air Conditioning

IAW—In Accordance With

IC—Incident Commander; also Infection Control

ICC—Installation Control Center

ICS—Incident Command System; ref. National Incident Management System (NIMS)

IDMT—Independent Duty Medical Technician

IDO—Installation Deployment Officer

IDP—Installation Deployment Plan

IDT—Inactive Duty Training

IGESP—In Garrison Expeditionary Site Planning

IMA—Individual Mobilization Augmentee

IM/IT—Information Management/Information Technology

IMR—Immediate Medical Response; also Individual Medical Readiness

IPR—Individual Personnel Readiness

IS—Information Systems

ISDRT—Information Services Disaster Response Team

ITB—Interfacility Transfer Brief

IV—Intravenous

JBAIDS—Joint Biological Agent Identification Diagnostic System

JCS—Joint Chiefs of Staff

JET/IA—Joint Expeditionary Tasking/Individual Augmentee

JIT—Just-In-Time

JLLIS—Joint Lessons Learned Information System

JOMMC—Joint Operations Medical Managers Course

JTF—Joint Task Force

JTTR—Joint Theater Trauma Registry

JTTS—Joint Theater Trauma System

Kx—Knowledge Exchange

L2—Lessons Learned; also LL

LAF—Line of the Air Force

LBDT—Laboratory Biological Detection Team

LMR—Land Mobile Radio

LOAC—Law of Armed Conflict

LOE—Letter of Evaluation

LRN—Laboratory Response Network

LSISS MTF—Limited Scope with Inter-Service Support Medical Treatment Facility

LS MTF—Limited Scope Medical Treatment Facility

M&M Conference—Morbidity and Mortality Conference

MAA—Mutual Aid Agreement

MAF—Mobility Air Forces

MAJCOM—Major Command

MASF—Mobile Aeromedical Staging Facility

MCC—Medical Control Center

MC—CBRN - Medical Counter-CBRN

MCOOP—Medical Continuity of Operations

MCRP—Medical Contingency Response Plan

MED PDB—Medical Product Data Bank

MEDEVAC—Medical Evacuation

MEFPAK—Manpower and Equipment Force Packaging System

MEM—MTF Emergency Manager

MET—Mission Essential Task

METL—Mission Essential Task List

MFR—Memorandum for Record

MILPDS—Military Personnel Data System

MIRC—Medical Intelligence Readiness Command

MISCAP—Mission Capability

MOA—Memorandum of Agreement

MOPP—Mission-oriented Protective Posture

MOU—Memorandum of Understanding

MPA—Military Personnel Appropriation

MPAT—Military Patient Administration Team

MR—Medical Readiness

MRA—MEFPAK Responsible Agency

MRC—Medical Readiness Committee; replaced Medical Readiness Staff Function (MRSF)

MRDSS—Medical Readiness Decision Support System

MRDSS ULTRA—Medical Readiness Decision Support System Unit-level Tracking and Reporting Application

MRL—Medical Resource Letter

MRM—Medical Readiness Manager

MRMC—Medical Readiness Management Course; replaced Medical Readiness Planners Course (MRPC)

MRNCO—Medical Readiness Noncommissioned Officer

MRO—Medical Readiness Officer

MRSA—Methicillin-resistant Staphylococcus aureus

MRT—Medical Readiness Training

MRTS—Medical Readiness Training Site

MRTES—Medical Readiness Training and Exercise Schedule

MSC—Medical Service Corps

MTF—Medical Treatment Facility

MTT—Mobile Training Team

MTW—Major Theater War

NAF—Numbered Air Force

NATO—North Atlantic Treaty Organization

NBC—Nuclear, Biological, Chemical

NBCC—Nuclear, Biological, Chemical, and Conventional

NCMI—National Center for Medical Intelligence

NDMS—National Disaster Medical System

NGB—National Guard Bureau

NIMS—National Incident Management System

NIPRNET—Non-secure Internet Protocol Router Network

NMC—Not Mission Capable

NLT—Not Later Than

NREMT—National Registry of Emergency Medical Technicians

NRF—National Response Framework

O&M—Operations and Maintenance

OCONUS—Overseas Continental United States

OCR—Office of Collateral Responsibility

OCO—Overseas Contingency Operations

OEBGD—Overseas Environmental Baseline Governing Document

OEH—MIS - Occupational & Environmental Health-Management Information System

OG—Operations Group

OJT—On-the-job Training

OPCON—Operational Control

OPLAN—Operation Plan

OPR—Office of Primary Responsibility

OR—Operating Room

ORE—Operational Readiness Exercise

ORI—Operational Readiness Inspection

OSAT—Overseas Annual Tour

OSI—Office of Special Investigation

OSL—Over Sized Litter

OSM—Operational Support Medical

OTS—Officers Training School

PA—Public Affairs

PAD—Patient Admissions and Dispositions

PAFSC—Primary Air Force Specialty Code

PAR—Population at Risk

PCA—Permanent Change of Assignment; also Patient Controlled Analgesia

PCS—Permanent Change of Station

PEM—Program Element Manager (Monitor)

PERSCO—Personnel Support for Contingency Operations

PHA—Preventive Health Assessment

PHEO—Public Health Emergency Officer

PHNCO—Public Health Non-commissioned Officer

PHO—Public Health Officer

PHTLS—Prehospital Trauma Life Support

PI—Pandemic Influenza

PIES—Post-Incident/Exercise Summary

PIMR—PHA/Individual Medical Readiness

PMC—Partially Mission Capable

PMEL—Precision Measurement Equipment Laboratory

PMI—Patient Movement Item

POC—Point of Contact

POD—Point of Debarkation; also Point of Dispensing

POM—Program Objective Memorandum

PPBES—Programming, Planning and Budgeting Execution System

PPE—Personal Protective Equipment

PRC—Primary Receiving Center

PRN–Medical abbreviation for “as needed” or “as the situation demands”

PRT—Patient Reception Team

QA—Quality Assurance

RCA—Readiness Case Analysis

RCOT—Reserve Commissioned Officer Training

RDD—Required Delivery Date

RDS—Records Disposition Schedule

RMO—Resource Management Office

RP—Reportable Percentage

RPA—Reserve Personnel Appropriation

RSVP—Readiness Skills Verification Program

RTOC—Readiness Training Oversight Committee

SABC—Self-Aid and Buddy Care

SAV—Staff Assistance Visit

SEI—Special Experience Identifier

SFS—Security Forces Squadron

SIPRNET—Secret Internet Protocol Router Network

SITREP—Situation Report

SLEP—Shelf Life Extension Program

SME—Squadron Medical Element; also Subject Matter Expert

SNS—Strategic National Stockpile

SOF—Special Operations Forces

SORTS—Status of Resources and Training System

SSC—Secondary Support Center

SSS—Staff Summary Sheet

STARS—P – Sustainment of Trauma and Resuscitation Skills Program

STE—Secure Terminal Equipment

STU—Secure Telephone Unit

TAA—Training Affiliation Agreements

TACON—Tactical Control

TBMCS—Theater Battle Management Core Systems

TC2—Tactical Command and Control

TDY—Temporary Duty

TFMED—Task Force Medical

TLAMM—Theater Lead Agent for Medical Materiel

TLN—Training Line Number

TMDS—Theater Medical Data Store

TMIP—Theater Medical Information Program

TMO—Traffic Management Office

TPFDD—Time-Phased Force Deployment Data

TR—Traditional Reservists

TRANSCOM—US Transportation Command

TRG—Training Group

TSR—Traumatic Stress Response

TTP—Tactics, Techniques and Procedures

TTX—Tabletop Exercise

UCC—Unit Control Center

UCI—Unit Compliance Inspection

UDM—Unit Deployment Manager

UGT—Upgrade Training

UJTL—Universal Joint Task List

ULN—Unit Line Number

ULTRA—Unit- Level Training and Reporting Application

UMD—Unit Manning Document

USAFSAM—US Air Force School of Aerospace Medicine

UTA—UTC Availability (replaced the AFWUS); also Unit Training Assembly

UTC—Unit Type Code

UTL—Universal Task List

VA—Veterans Administration

VTC—Video Teleconference

WBT—Web Based Training

WMD—Weapons of Mass Destruction

WMP—War Mobilization Plan

WRM—War Reserve Materiel

Terms

Aeromedical Evacuation (AE).—The movement of patients under medical supervision by medical teams to and between medical treatment facilities by fixed wing aircraft.

Annual Training—. A training period related to the calendar year. Training required on an annual basis must be accomplished every calendar year, but not exactly every twelve months, e.g., an individual who attends an annual training event on 1 Jan 2009 is current until 31 Dec 2010.

Community Recovery.—The process of assessing the effects of an Incident of National Significance, defining resources, and developing and implementing a course of action to restore and revitalize the socioeconomic and physical structure of a community.

Core requirements.—Those essential individual training requirements needed to accomplish the AFMS mission.

Critical Infrastructur—e. Systems and assets, whether physical or virtual, so vital to the US that the incapacity or destruction of such systems and assets would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

Defense Support of Civil Authorities (DSCA)—. Refers to DOD support, including Federal military forces, DOD civilians and DOD contractor personnel, and DOD agencies and components, for domestic emergencies, and for designated law enforcement and other activities.

Disease Prevention.—Encompasses the anticipation, prediction, identification, prevention, and control of preventable diseases, illnesses, and injuries caused by exposure to biological, chemical, physical or psychological threats or stressors found at home station and during deployments.

Emergency Operations Center (EOC).—The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be located in a permanent or temporary location. EOCs may be organized by major functional disciplines (fire, law enforcement, medical services, etc.), by jurisdiction (Federal, State, regional, county, city, tribal), or by some combination.

Emergency Responders (medical). Disaster Response Force members who deploy after first responders and provide additional support. They include follow— on medical personnel including additional ambulances, physicians, nurses, technicians, and other specialized teams. Teams such as radiology, laboratory, pharmacy, surgery, and nutritional medicine would not ordinarily leave the facility and are therefore not considered emergency responders. Examples of MCRP teams in the emergency responder category would be the Field Response Team, Triage Team, the Public Health Team, and the Nursing Services Team.

Emergency Support Function—. A grouping of government and certain private sector capabilities into an organizational structure to provide the support, resources, program implementation, and services to help communities recover following domestic incidents.

Federal Coordinating Center (FCC)— A facility located in a metropolitan area of the United States, and Puerto Rico, responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA). **Note:** The main difference between the FCC and the Primary Receiving Center (PRC) mission is FCCs coordinate planning, training, exercising, and operations of one or more NDMS PRAs. PRCs receive; triage, stage, transport, and track patients affected by a disaster to participating NDMS inpatient hospitals capable of providing the required definitive care.

Incident Commander.—The individual with the overall authority and responsibility for conducting incident operations and is responsible for the management of all operations at the incident site, including the development of strategies and tactics and ordering the release of resources.

Incident of National Significance.—Refer to the National Response Framework or HSPD 5 for criteria and examples.

Installation Medical Response. Term that encompasses the full spectrum of installation medical response activities, including medical contingency response, WMD response, MC—CBRN response, home station medical response, defense support to civil authorities, civil support, and disaster response.

The Joint Commission.—Previously called the Joint Commission on Accreditation of Healthcare Organizations. The name change reflects the Joint Commission's continuing efforts to improve the value of accreditation and its utility as a mechanism for improving the quality and safety of patient care in all organizations.

Just—**In-Time (JIT) Training.** Training that augments core requirements and occurs in conjunction with activities in support of expeditionary and disaster response operations. Training is normally time sensitive and usually limited to that period of time that immediately precedes the activity, deployment or function.

Limited Scope (LS) and Limited Scope with Inter—**service Support (LSISS)** MTFs. LS MTFs are defined as units with less than 75 assigned personnel. LSISS MTFs are tenant units on bases where at least two Services share resources. Joint base MTFs that are host units are not considered LSISS MTFs.

P- Codes.—The P-Code structure is used in conjunction with Non-standard UTC (NSUTC) Codes to restrict/prioritize UTC utilization. They are defined as follows

1 = DWS	2 = AWS
3 = DXS	4 = AXS
5 = DWX	6 = AWX
7 = DXX	8 = AXX
A = DPS	B = APS
C = DPX	D = APX

Patient Reception Area (PRA)—A geographic locale containing one or more airfields, bus stations, or airfields; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to pre-identified, non-Federal, acute care NDMS hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency. Generally, these hospitals are within a 50 mile radius.

Primary Receiving Center (PRC)—A Military Treatment Facility (MTF) or VA Medical Center (VAMC) designated for coordinating and/or providing treatment to sick and wounded military personnel returning from armed conflict or national emergency. The main difference between the FCC and the PRC mission is FCC's coordinate planning, training, exercising and operations of one or more NDMS Patient Reception Areas. FCCs receive; triage, stage, transport and track already-inpatients affected by a disaster to participating NDMS inpatient hospitals capable of providing the required definitive care. The patients will more than likely not be eligible for care in a Federal treatment facility. The mission of a PRC is to receive and treat sick and wounded military personnel returning from armed conflict or national emergency.

Patient Reception Team (PRT)—A multi-function group consisting mainly of clinical staff, but also including appropriate support from medical administration, communications, logistics, litter-bearers, drivers, etc., to support the NDMS mission. The team may consist of military and/or civilian personnel, depending on the local FCC. The mission of the PRT is to receive, sort, triage, and care for patients as they arrive at the PRA awaiting distribution to NDMS hospitals. The PRT regulates and transports patients to area NDMS hospitals and monitors NDMS patients' status, location, care, and costs then assists returning patients back to home or duty station

Secondary Support Center (SSC)—Military Treatment Facility (MTF) or VA Medical Center (VAMC) designated to accept transfers from, or sharing resources with, a Primary Receiving Center (DOD or VA Only) to maximize health care services support to the DOD.

Sustainment Training— Training required to maintain or enhance the proficiency of individual readiness, clinical, and unit/platform skills.

Training Cycle—That period of time, as defined by each service component, in which all mandatory medical readiness training must be completed. The Air Force training cycle currently coincides with the AEF cycle.

Wound and Casualty Management—Wound management refers to those medical skills that are needed to care for trauma and disease non- battle injury patient conditions. Casualty management refers to those skills that are needed to triage and regulate casualties, to include land and air medical evacuation, and staging.

ATTACHMENT 2

MEDICAL CONTINGENCY RESPONSE PLAN (MCRP) FORMAT

A2.1. Cover Page. Include the publication date, title, base, and OPR.

A2.2. Letter of Transmittal. Include the title, purpose, and plan review schedule, as a minimum. The letter of transmittal is signed by the MTF commander.

A2.3. Security Instructions and Record of Changes

A2.4. Plan Summary. The plan summary should resemble an executive overview, addressing key issues and concepts described in the plan. Include the plan purpose, conditions of implementation, operations to be conducted, key assumptions, operational constraints, command relationships, and a consolidated listing and impact assessment of shortfalls and limiting factors.

A2.4.1. **Key Assumptions.** The following assumptions should be included in the plan, as applicable.

A2.4.1.1. Fire/rescue personnel will respond and assist in accordance with their standard operating procedures.

A2.4.1.2. The MTF will have an initial response capability as described in paragraph 2.1.16.7.2.

A2.4.1.3. CBRN incidents may occur on or near the installation.

A2.4.1.4. The surrounding civilian hospitals will accept patient transfers in accordance with TRICARE and support agreements.

A2.4.1.5. Wing military resources and personnel will be available for use during contingencies.

A2.4.1.6. Supplies, equipment, and funds will be made available upon implementation of this plan to sustain increased ops tempo.

A2.4.1.7. Deployable resources may be deployed and unavailable when an incident occurs.

A2.5. Table of Contents.

A2.6. Basic Plan. Include a list of supporting plans and agencies, as well as a list of references used in the development of the plan (each reference does not require a specific date). Include Federal, DOD, AF, and MAJCOM guidance as well as any applicable installation and unit guidance. Also list applicable maps and charts.

A2.6.1. **Unit Missions.** Provide an overview of the unit's deployment and generation missions to include casualty receiving hospital, facility expansion requirements, NDMS support, etc. Consult MRDSS ULTRA for a full list of generation missions which should be included in this section.

A2.6.2. **Contributing Organizations**. Include all units and organizations (military and civilian) that have a role in the plan or support the medical facility during contingency response operations. Briefly describe the support provided by these entities, a means of activating support agreements, if applicable, and provide a point of contact with a current

address and phone number. MOUs/MOAs/MAAs and applicable contracts containing contingency response clauses must be fully coordinated in writing and maintained in the MR office. All on-base contributing organizations identified in the plan must coordinate on it prior to publication.

A2.6.3. **Execution.** Describe the conditions under which the MCRP will be executed, who directs the execution, and who executes the plan. Briefly summarize each annex, providing a descriptive statement for each major team, as appropriate, with the corresponding annex. The descriptive statement should indicate who is responsible for preparing and maintaining each annex and any supporting MCRP team checklists. Include a statement: "Each MCRP annex must be exercised annually. Required reading for all unit personnel includes: Basic Plan, Annexes A, M, O, P, Q, T, and their own team annex"

A2.6.4. **Threat Assessment**. DoDI 6055.17 requires installations to conduct a vulnerability assessment in coordination with Anti-Terrorism (AT) program and Defense Critical Infrastructure Program (DCIP) to address the broad range of hazards and/or threats (including CBRN hazards). Describe legitimate facility threats, to include: security issues, critical infrastructure, weather or geological concerns, CBRN, and other hazards. Address specific vulnerabilities, limiting comments to unclassified sources. Medical units can access local vulnerability information from the local Threat Working Group or AT/FP office.

A2.7. Annexes. Each annex provides definitive information as to how, where, when, and who performs specific functions in support of the unit's contingency response mission, allowing for the flexibility to adapt to changing emergency situations or environments and still effectively execute the mission. Each team annex should specifically address all environments in which teams may be required to respond and operate, including accidents, natural disasters, and terrorist incidents, and when computerized procedures are not available. CBRN factors could be part of any response activity and therefore MC-CBRN responsibilities should be included in all MCRP team annexes and checklists. MCRP teams will be organized, trained, and equipped as determined by the MRC. MCRP team chiefs are the Annex OPRs and are responsible for preparing and maintaining their annexes and all supporting team checklists. Each annex should specify its OPR by position, as in "The Administrator is the OPR for this Annex." Supporting MCRP team checklists must be designed to serve as a quick reference, chronological list of actions required in any given situation. Checklists must be easily accessible during an emergency and extra copies maintained at the MCOOP alternate command and control (C2) location in the event of a facility evacuation/relocation. List supporting MCRP team checklists (by subject or title) within each applicable annex. Include annexes listed in the following paragraphs, as a minimum. If an annex from this list does not apply, include the title page with an explanation for the omission. To accommodate unique local requirements, additional appendices and tabs not assigned in this attachment may be added (e.g. Annex Y and Z).

A2.7.1. **Annex A - General Instructions.** Include information applicable to all medical personnel regardless of team assignment. Address the following:

A2.7.1.1. Recall Procedures. Recalls are initiated at the direction of the wing or unit commander, or designated representative, to return medical personnel to duty in response to emergencies, disasters, contingencies, or to transmit important information. Total and selective recalls should be considered in recall procedure development. The total recall is used to recall the entire unit and may involve telephone notification and reporting to duty

or telephone notification to relay important, or time sensitive, information. The selective recall may involve the recall to duty of smaller groups including UTC personnel, deployment support teams, or key individuals or specific MCRP teams. The selective recall may also be used to relay important information, such as pending activation, to specific individuals. Units may elect to supplement or modify the recall procedures described here to fit special or unique circumstances, as appropriate. For example, overseas locations may consider development of "communications out" procedures if standard communications systems are routinely unavailable.

A2.7.1.2. Space Allocation. Include a description and diagram of team work spaces as well as anticipated patient flow within the facility during a contingency. Include any team operation areas that are outside the facility as well, such as patient decontamination or triage.

A2.7.1.3. Triage Categories. Include a description of the triage system used on the installation and ensure it complies with AFTTP 3-42.32 para 11.4.4.2.2. The following categories and colors are used for standardization during triage:

MINIMAL - **Green**
DELAYED - **Yellow**
IMMEDIATE - **Red**

In joint military/civilian exercises or actual events, coordinate with local emergency response agencies to ensure consistency. **Note:** EXPECTANT patients would normally be those patients who require extensive medical treatment so as to detrimentally impact the health or treatment of other patients. As a rule, this category is not applied in a peacetime disaster due to the wide range of medical treatment options.

Base Mission Support. Outline the MTF's role in supporting the base mission with a clear delineation between deployment operations and installation medical response. Address the MTF's role in supporting base response. Do not duplicate guidance contained in other plans but ensure vital information is available when needed. In addition, address medical support for the wing EOC. Refer to, but do not duplicate, information or guidance addressed in Annex T.

A2.7.1.4. Command, Control, Communications, Computers, and Information (C4I). Indicate the location of the MCC and describe available C4I infrastructure. Include as description of MTF roles and lines of communication within the installation AF Incident Management System (AFIMS) structure. Describe back-up resources and procedures for maintaining communications and connectivity in the event of an outage. List actions required to restore communications and information systems connectivity if they break down, including repair points of contact and other base support. See Annex P for additional communications resources and information.

A2.7.1.5. Base Mission Support. Outline the MTF's role in supporting the base mission with a clear delineation between deployment operations and installation medical response. Address the MTF's role in supporting base response. Do not duplicate guidance contained in other plans but ensure vital information is available when needed. In addition, address medical support for the wing EOC. Refer to, but do not duplicate, information or guidance addressed in Annex T.

A2.7.1.6. Response Codes. Units that have internal emergency response code systems (code pink for child abduction, code red for fire, etc.) will describe those codes and associated response procedures in this annex and incorporate these activities into exercise scenarios whenever possible.

A2.7.2. **Annex B - Medical Command and Control.** Describe the responsibilities of the MTF commander both before and during a disaster/contingency. List commander's responsibilities including providing command and control over MCRP team functions within the medical treatment facility and coordinating with the Emergency Support Functions (ESF) 8 and 11 representatives in the EOC, using the Air Force Incident Management System (see AFI 10-2501 for more information). Provide EOC support details. **Note:** The incident commander has tactical control of medical personnel at the incident site. Identify the unit's chain of command, and list key and emergency staff for MCOOP operations, describing delegations of authority established for an event that renders key leaders unavailable or incapable of performing their duties. This Annex has an Appendix for the MCC Team and a second Appendix on Medical Reporting.

A2.7.2.1. Appendix 1 – MCC. Identify roles and responsibilities, including primary role as medical communication and coordination focal point. Describe primary and alternate work locations and relocation procedures. Identify events log components and disposition. Maintain casualty status logs. Identify methods to support timely casualty tracking and patient, manpower, equipment and supplies status reporting through the entire event lifecycle to the EOC and/or wing commander, as required. Identify medical representatives to EOC and other C2 organizations, when not the commander.

A2.7.2.2. Appendix 2 – Medical Reports. Describe and provide a sample MEDRED-C and NDMS Bed Status Report, if applicable.

A2.7.3. **Annex C - Patient Support.** Address maximum anticipated patient population during contingencies, projected changes in availability of medical services, including curtailment of routine services during contingency operations, and resulting patient redistribution. Address enrolled patients as well as potential non-enrolled patients, such as base civil service employees or contractors who may seek care during an emergency. If routine care will not be curtailed, describe prioritization of care.

A2.7.4. **Annex D - Casualty Management**. Describe casualty management for each respective team/work center, to include casualty flow within the facility and transportation of casualties to the MTF and other facilities. Outline procedures to respond to all contingencies, including procedures outlined in TTP 3-42.32, *Home Station Medical Response to CBRNE Events*.

A2.7.4.1. Appendix 1 - Field Response Team (formerly known as Aerospace Medicine Team and/or Field Treatment Team/Immediate Medical Response). This team should be comprised of at least one physician, one nurse, two med techs, and one patient administration technician to provide data collection and communications support on scene. This team provides the medical initial responders and any follow-on medical emergency responders to the scene as requested by the on-scene commander and is responsible for assessing the situation and requesting additional support as necessary. For units with a flying mission, Squadron Medical Element personnel may participate on this team. Additional providers, nurses and medical technicians may be assigned to this

team to supplement medical and transportation capabilities at the scene. Additional patient administration personnel assigned to this team can provide casualty tracking support and status updates. Utilize 886J AS for MC-CBRN response.

A2.7.4.2. Appendix 2 - Clinical Services. Teams that provide clinical services are covered in this Appendix as listed below. In facilities where there are limited physicians/providers, the MRC may designate a single Clinical Services Team to represent the Minimal, Delayed and Immediate teams. In that situation, the clinical services team chief is responsible for AS 886L and SG05.

A2.7.4.2.1. Tab 1 - Minimal Team. This team treats patients with minor injuries who require some attention, but whose injuries are so slight that they may not need a physician. Most of these patients can be returned to duty promptly. Include the radiological dose tracking procedures for personnel working outdoors as determined by the local radiation safety officer. Use 886L AS for MC-CBRN response.

A2.7.4.2.2. Tab 2 - Delayed Team. This team treats patients whose injuries are significant but not immediately life threatening. Injuries in this category may require surgery or extensive medical care. Use 886L AS for MC-CBRN response.

A2.7.4.2.3. Tab 3 - Immediate Team. This team treats patients whose injuries demand immediate medical or surgical intervention to save life or limb. The immediate team chief is responsible for maintenance of 886L AS for MC-CBRN response and SG05, Pandemic Influenza Supplies on behalf of the minimal, delayed, immediate and surgery teams. .

A2.7.4.2.4. Tab 4 - Radiology Team. This team provides diagnostic imaging support during contingency operations. Discuss exam prioritization.

A2.7.4.2.5. Tab 5 - Laboratory Team. This team provides diagnostic laboratory and potentially transfusion services in support of contingency operations. Use 886I AS for MC-CBRN response. The Laboratory Biological Detection Team (LBDT) is a sub-element of the laboratory team and must have the capability to identify biological agents of operational concern in environmental and clinical samples.

A2.7.4.2.6. Tab 6 - Pharmacy Team. This team prepares and distributes medications in support of contingency operations. Outline the mass prophylaxis plan to support pre- and post-exposure requirements. Outline procedures to request assets from the Strategic National Stockpile (SNS) (in CONUS) or established overseas stockpiles. Establish procedures for a mass prophylaxis distribution process. Include installation distribution priorities, locations, tracking mechanisms, and training requirements. Ensure the installation mass prophylaxis plan addresses procedures for radiological countermeasures as necessary. Refer to but do not duplicate information provided in the Mass Prophylaxis Plan or Disease Containment Plan. Utilize 886E AS for MC-CBRN response and SG06 for Pandemic Influenza Pharmaceuticals.

A2.7.4.2.7. Tab 7 - Surgery Team. This team provides surgical support for contingency operations. Units that do not have surgical capability will address how they will manage surgical casualties and where/how they will be transferred for surgical services. Use 886L and 886D AS for MC-CBRN response.

A2.7.4.2.8. Tab 8 - Nursing Services Team. This team provides support to other teams as required and supports patient reception, stabilization, re-triage and transport, as necessary. The Nursing Services Team Chief is responsible for maintaining the 886D AS for MC-CBRN response.

A2.7.4.2.9. Tab 9 - Triage Team. The Triage Team support will be comprised of at least one provider (physician, dentist, PA or IDMT) and one nurse or medical technician to triage patients arriving at the medical unit (primary team) and a similar team to provide re-triage after patient decontamination (secondary team). If patient decontamination is not required, the primary triage team will rejoin the secondary triage team to transition into one team. The triage team should be activated at the same time as patient decontamination and security teams during a CBRN incident and at same time as the immediate, delayed and expectant teams during other mass casualty situations to ensure triage capability is available. Use 886K AS for MC-CBRN response.

A2.7.4.2.10. Tab 10 - NDMS Patient Reception Team. A multi-function group consisting mainly of clinical staff, but also including appropriate support from medical administration, communications, logistics, litter-bearers and drivers, etc., for MTFs officially tasked to support the patient reception NDMS mission. The team may consist of military and/or civilian personnel, depending on the local FCC. The mission of the PRT is to receive, triage, and care for patients as they arrive at the PRA, distribute patients to NDMS hospitals, and manage patient movement items (PMI). The PRT stations, regulates and transports patients to area NDMS hospitals and monitors NDMS patients' status, location, care, and costs then assists returning patients back to home or duty station

A2.7.5. **Annex E - Public Health Team.** Describe public health needs assessment techniques and procedures; site selection consultation; communicable and vector- borne disease surveillance, prevention, control, and reporting; food safety and decontamination oversight; food borne illness outbreak investigations and food vulnerability assessments; medical intelligence and health threat assessment; and deployment health threat management and education. Describe support to the PHEO during public health emergencies and installation contingency response. Use 886P AS for MC-CBRN response.

A2.7.6. **Annex F - Bioenvironmental Engineering (BE) Team.** Outline support provided by the BE team, to include evaluations or assessments of environmental and occupational health hazards and recommended actions for control of these hazards; in coordination with CE, monitoring of base water supply to ensure potability, safety, and survivability; monitoring, evaluation, and direction for control of chemical, biological, and radiological hazards; and assistance in selecting base and unit shelters. This annex should outline procedures for responding to all installation contingencies and utilization of the 886H AS for MC-CBRN response. Detailed guidance on ionizing radiation and dosimetry is contained in AFI 48-148, *Ionizing Radiation Protection* and AFMAN 48-125, *Personnel Ionizing Radiation Dosimetry*.

A2.7.7. **Annex G - Medical Logistics Team.** Planning shall include the identification of WRM management and maintenance requirements. Outline procedures for distribution of BW/CW antidotes to applicable deploying forces. Describe in-garrison mission support,

including procedures for emergency requisition and the biomedical equipment repair/maintenance program. Address logistics support requirements for mass prophylaxis planning and SNS assets. Address support to the MC-CBRN teams during a contingency and management of 886 AS.

A2.7.8. **Annex H – Manpower/Security Teams**. Recommend large facilities establish separate Security and Manpower teams; smaller facilities may combine these teams. The 886M AS responsibilities will be assigned to the Security team component and managed by the Security team chief if the teams are separate, or the joint team chief if organized as one.

A2.7.8.1. Appendix 1 – Medical Unit Security Team. Address the Security Team's roles in supporting wing/base terrorist threat procedures and in carrying out Force Protection Condition actions within and around the MTF during periods of heightened terrorist threats or activity and elevated Force Protection measures. Refer to base/wing force protection plans but do not duplicate guidance in these plans. Address at a minimum, facility security, entry control procedures, communications, and plans for 24-hour coverage if/when necessary, and security support for mass prophylaxis dispensing locations. Use 886M AS for MC-CBRN response. The security team must be trained in unit-specific procedures for securing their facility.

A2.7.8.2. Appendix 2 – Manpower Team. Describe how Manpower Team members are deployed and managed during an emergency, as well as team communications resources and procedures. All personnel not specifically assigned to another response team will be assigned to the Manpower Team. Describe manpower assignments to patient movement and facility evacuation support functions, when required. If additional manpower support will be requested from other base units in an emergency, address those procedures here.

A2.7.8.3. Appendix 3 – Manpower/Security Decontamination Support Team. This team consists of team members identified to support patient decontamination operations in the decontamination zone. Describe associated procedures and training requirements, to include enrollment in the respiratory protection program. Include procedures for simultaneous activation of this team with the Patient Decontamination and Triage teams in the presence of a CBRN threat or exposure, as well as procedures for supporting patient decontamination operations. Include the radiological dose tracking procedures for personnel working outdoors as determined by the local radiation safety officer.

A2.7.9. **Annex I – Traumatic Stress Response (TSR) Team.** Describe responsibilities in providing mental health services to patients and families in support of disaster response operations. Address team response and associated training in accordance with AFI 44-153, *Traumatic Stress Response.* Describe traumatic stress response (TSR) and hostage negotiation consultation missions. Discuss how the TSR team will support First and Emergency Responders.

A2.7.10. **Annex J - Facilities Management Team.** Describe facility management activities in ensuring maintenance and repair support; availability of required utilities; and maintenance or repair of communication assets. Include procedures in response to contingency events, to include but not limited to, oxygen shut-off procedures and locations; HVAC shut-off procedures and locations; power locations; emergency water shut-off, alternate water source, and emergency entry control. Describe relationships and communication between the Security Team, Manpower Team and the Facilities Management

Team during building evacuation and lock-down, force protection condition response, or patient/public movement control/restrictions within and around the facility.

A2.7.10.1. Appendix 1 – Describe fire evacuation/protection plan and associated references, including assembly maps, alarm procedures and RACE (Rescue, Alert, Contain, Extinguish).

A2.7.10.2. Appendix 2 – Describe facility reconstitution procedures following a catastrophic event that renders the MTF uninhabitable (MCOOP).

A2.7.11. **Annex K - Nutritional Medicine/Food Service Team.** Address food service functions during contingency operations even if the facility has no in-house food preparation capability. Describe feeding patients and responders during a mass casualty or contingency event. Address how and where meals would be procured and distributed; consider feeding personnel during MCOOP operations, evacuation or shelter scenarios.

A2.7.12. **Annex L - Patient Administration Team**. Describe patient administration functions during all contingency scenarios. Describe plans for patient movement, patient tracking and status reporting procedures for both patients within the facility and those transported to other area medical facilities. If appropriate, the Patient Administration Team may be sub-divided to cover different areas of the facility where patients may enter or where data may be captured.

A2.7.13. **Annex M - Civil Disturbances.** Civil disturbances may be defined as incidents which result in, or could result in, disruption of normal community life, injuries, loss of life, and/or destruction of property. It may or may not include military personnel. Describe how the MTF will respond and provide medical care to persons injured as a result. This annex should include identification of likely scenarios, the impact on the facility operations, and recommendations to mitigate that impact.

A2.7.14. **Annex N – Patient Decontamination.** This annex outlines how the MTF, with or without inpatient capability, will provide thorough patient decontamination prior to patients entering the MTF or being transported to off base definitive medical care. The MTF will utilize the 886A AS or a permanent fixed-facility decontamination capability, if available. Describe how the Triage Team and Security Team will integrate their capabilities to support patient decontamination operations. Recommend facility commander augment this team with additional personnel to ensure a round-the-clock capability. Existing patient decontamination procedures are valid for radiological events. Ensure that effluent containment requirements determined by the local CE Environmental office are included in Annex N. Consider all open wound/s contaminated until proven otherwise. The first priority is to treat life or limb threatening conditions using standard precautions before conducting patient decontamination. Otherwise, removing clothing and decontamination by soap and water must be performed prior to treatment.

A2.7.15. **Annex O - Transportation.** Address requirements for medical transportation, materiel handling, and personnel support. Describe plans for patient transportation during a mass casualty event, including any MOUs/MOAs/MAAs for additional vehicles to augment current capabilities, or for transportation support from local civilian sources. Address deployment requirements for movement, marshalling and staging of medical personnel, baggage, WRM (if applicable) and other resources to fulfill mission requirements. Address

procedures for sheltering vehicles in response to impending storms or other events, as applicable. Include the procedures identified in local MOUs/MOAs/MAAs for transportation for potentially contaminated patients.

A2.7.16. **Annex P - Medical Continuity of Operations (MCOOP).** Describe the unit's MCOOP procedures as directed in paragraph 5.4.2 of this Instruction. Include a list of the unit's prioritized mission essential functions (MEF). Describe procedures for immediate staff accountability following an event, including procedures for dispersing staff to local civilian hospitals or other agencies if directed by MOUs/MOAs/MAAs. Address the transfer of any necessary equipment or supplies to augmented facilities. If immediate evacuation of the MTF is required, describe procedures for evacuation/dispersion of patients and reference established MOUs/MOAs/MAAs for transfer of patients to other medical facilities, as applicable. Describe procedures for the actual transportation of patients to dispersed locations and how the determination will be made as to which types of patients go where. Describe where and how patients will be staged while awaiting transport, and which MCRP teams will support operations at that location. Consider the need for sheltering in place if evacuation is not possible and address those procedures in Annex Q, Shelter Operations, referencing that annex as necessary. If appropriate, reference Annex C for patient dispersal procedures, rather than duplicating guidance. Reference Annex L for patient tracking procedures following dispersal and during the event. Include the following appendices:

A2.7.16.1. Appendix 1 - Medical C4I. Address notification and relocation of the MCC and key staff to an alternate location from which they will track patients, perform staff accountability functions, and provide status updates to wing leadership and higher headquarters as requested. Describe methods that will be utilized to alert unit personnel, local civilian facilities and emergency responders, base agencies, and higher headquarters of a catastrophic event. Address alternative methods for ongoing communications with the aforementioned agencies/personnel to provide updates, request assistance, etc. Include a list of land line phone numbers that can be used, including secure communications resources and capabilities. In addition, address procedures to establish information systems capability at the medical C2 location. Describe redundant or back-up procedures for patient accountability and tracking, and for providing in an appropriately secure manner necessary patient care information to receiving facilities to minimize disruption of care. Address how situational awareness will be maintained to aid key leaders in making appropriate and timely decisions and provide an accurate common operating picture to higher headquarters.

A2.7.16.1.1. Tab 1 - Information Services Disaster Response Team (ISDRT). This team may be a sub-team of the MCC but must have the capability to be activated independently. Personnel on the ISDRT should not be assigned duties on other disaster teams, but may be used as manpower support when not activated. Reference paragraph 5.4.2.2 of this Instruction for additional guidance and team responsibilities to include in this annex.

A2.7.16.1.2. Tab 2 - Public Information. Identify methods for providing public information announcements and situation updates to beneficiaries and dispersed staff members. Also consider providing specific information on alternate sources of care.

A2.7.16.2. Appendix 2 – Staff Transportation. Describe transportation procedures for dispersed staff, including use of POVs and procurement of alternate means of transportation if necessary. Patient transportation is addressed in Annex O.

A2.7.16.3. Appendix 3 – Return to Normal Operations. Finally, describe procedures for an orderly return to normal operations at the MTF following reconstitution and termination of the event, referencing Annex J, Appendix 2 as necessary.

A2.7.17. **Annex Q - Shelter Operations.** Two types of shelters should be addressed in this annex: sheltering in place, within the facility during a sudden severe storm, such as a tornado, or a HAZMAT event on base, and evacuation to an external designated shelter for an imminent, more extended event, such as a hurricane. This annex will outline procedures for both scenarios. Describe procedures for moving staff, patients, supplies, and equipment to shelter areas/spaces, as well as patient care and response capabilities from and within the shelter. Describe how long shelter operations can be sustained and supplies required for sustainment. Address the types of patients, staff and civilians who might be in the shelter and how their needs will be met. For shelter in place operations, include diagrams of the shelter area, location of shelter kits, and number of vents, windows and doors that must be sealed. Identify protection factors for selected shelters. If patients and staff are to be evacuated out of the area during a hurricane or similar event, describe how the evacuation will take place, roles and responsibilities during evacuation, and patient and staff tracking/contact throughout the event.

A2.7.18. **Annex R - NDMS Peacetime Operations.** This annex is only required for MTFs with formal NDMS-FCC roles. MTFs not designated as FCCs may optionally use this annex to describe potential involvement with NDMS operations, if applicable. PRCs and SSCs do not require a formal, stand-alone plan. PRC and SSC Facilities will incorporate all PRC and SSC specific responsibilities into Annexes C, D, L, O, V, X of the MCRP. If not formally assigned an NDMS mission, at a minimum identify the nearest PRC and any MTF responsibilities identified in the MOU/MOA/MAA.

A2.7.18.1. The MCRP must reference the developed NDMS-FCC Operations Plan in this annex. This annex is not a substitute for the NDMS FCC Operations Plan.

A2.7.19. **Annex S - Deployment.** Describe the processes involved in managing and deploying UTCs apportioned in the MRL. Include personnel selection and AFDF management, equipment and supplies, WRM management, weapons management, unit pre-processing, base deployment processing, and cargo marshalling. Address support the MTF provides to the base deployment processing and identify personnel who will comprise the deployment support team. Do not duplicate information contained in the installation deployment plan, but address procedures and guidance specific to the MTFs role in base deployment processing, such as pre- and post-deployment health screening, deployable medical records management, immunizations, prophylaxis distribution, and the medical intelligence briefing.

A2.7.20. **Annex T - Disaster Recovery.** Use this annex to describe recovery and reconstitutions procedures following "worst case" scenarios, such as a catastrophic natural disaster directly affecting the installation and/or surrounding civilian communities. Response procedures should have been addressed in other annexes. This annex should address specific procedures for medical facility reconstitution, MAJCOM and high headquarters coordination,

and reestablishing health care for active duty and non-active duty beneficiaries. Reference Annex J as applicable to avoid duplication.

A2.7.21. **Annex U - Blood Program.** Describe procedures necessary to provide blood and blood products for casualty treatment, if applicable. Indicate agreements with local agencies for obtaining emergency blood supplies, as appropriate. Designated AF Blood Donor Centers should describe procedures, personnel requirements, and facilities necessary to continue and/or expand blood collection activities. Facilities with in-place frozen blood teams should specify provisions for activation, operation, and resupply.

A2.7.22. **Annex V - Aeromedical Evacuation.** Use this annex to describe the facility's AE role and AE interface with base response activities, as applicable. Include a description of aeromedical staging activities and communications between the Aeromedical Staging Facility, PMI Center/Resupply, and MTF, as applicable. Describe civilian patient airlift capabilities and any MOUs/MOAs/MAAs involved. Describe procedures to be used in the event of an unanticipated diversion of AE missions to the base, or the unplanned requirement to support patients, both inpatient and outpatient, remaining overnight.

A2.7.23. **Annex W - TRICARE.** Address the role of the TRICARE contractor during contingency operations. Include information from the contractor's contingency plan in this Annex and list it in the References section as well. Discuss contractor responsibilities regarding changes in the MTF capabilities and capacities; NDMS associations; continuous care provisions during contingency operations; and exercise participation.

A2.7.24. **Annex X - Facility Expansion.** This annex is mandatory for MTFs tasked with a facility expansion mission and not required for MTFs that do not provide that capability. Include manpower and staffing requirements, equipment availability, and a description of facility expansion procedures and the expansion floor plan.

A2.7.25. **Annex Y (For Local Unit Use).**

A2.7.26. **Annex Z (For Local Unit Use).**

A2.8. Distribution. List all agencies/units which receive a copy of the plan, to include contributing agencies and civilian partners, and the number of copies they should receive.

ATTACHMENT 3

MEDICAL READINESS TRAINING (MRT) REQUIREMENTS

A3.1. AFMS-unique training requirements are listed in this attachment. Additional readiness training requirements may be levied by other AFIs, official messages, reporting instructions or guidance memos. Personnel must comply with all requirements until those requirements are officially rescinded by the governing authority. LS and LSISS MTFs see paragraph 6.1.7 of this Instruction for specific MR training guidance.

Table A3.1. CATEGORY I – INDIVIDUAL TRAINING. This AFSC-specific training is required for AD and ARC medical personnel (except interns, students, residents and personnel in fellowship training status) as indicated in the table below, regardless of their deployment status.

Training Requirement	Minimum Frequency	Reportable	Reference	Definition	Remarks/Training Source
Readiness Skills Verification Program (RSVP)	IAW Task Frequency	N	AFI 41-106	RSVP is AFSC-specific sustainment training and represent the minimum skills required for an individual to perform their duties in support of expeditionary and HA/DR operations.	Required for medical personnel. Institutional Force (IF) personnel will accomplish RSVP just-in-time (JIT), upon receipt of a medical deployment tasking. All RSVP training must be complete prior to deployment. **Source**: Checklists are available in MRDSS ULTRA at: https://mrdss1.gunter.af.mil/ultra4/login and on the AFMS Kx site at: https://kx.afms.mil/rsvp
Centers for Sustainment of Trauma and Readiness Skills (C-STARS)	Every 24 months	N	AFI 41-106	Military-civilian partnerships offering providers, nurses, and clinical technicians advanced AFSC-specific sustainment training at civilian Level-1 trauma centers.	Specialties are listed in the C-STARS Training Matrix on the AF Medical Readiness CoP. See para. 6.3.2. **Source**: Level-1 trauma centers in Baltimore and St. Louis
Sustainment of Trauma and Resuscitation Skills Program (STARS-P)	Local shifts twice per month on average, or one full week every 3 months	N	AFI 41-106	Staff immersion in ongoing clinical rotations at local Level-1trauma centers for providers, nurses and clinical technicians.	Participants may be eligible for C-STARS credit. See para. 6.3.3. Source**:** STARS-P platforms.
CBRNE Emergency Preparedness and Response Course (EPRC)	- Initial training within 12 months of first duty assignment - Sustainment training every 36 months	N	AFI 41-106 ASD-HA ltr, 28 Jun 07	Clinician/Provider, Executive/Commander, Operator/Responder, and Basic courses are defined in para. 6.3.4.	**Source:** Fulfilled through completion of CBRNE EPRC CBT on the JKO, accessible via the AF Portal. Credit is granted for Threat and Future Battlefield, Depleted Uranium, and Medical Effects of CBRN Warfare upon completion of this course. See the AF Medical Readiness CoP.

Table A3.2. CATEGORY II – DEPLOYMENT TRAINING. Personnel assigned to A/DWS/DWX/DXS coded UTCs must accomplish Category I training and Category II training. Additional training may be required to meet theater-specific requirements. Theater-unique training requirements will be identified in deployment reporting instructions and/or line remarks.

Training Requirement	Minimum Frequency	Reportable	Reference	Definition	Remarks/Training Source
UTC-Specific Training	- Initial upon assignment to a UTC - Sustainment training every 24 months or as described in para. 6.4.1.	Y	DODI 1322.24 AFI 41-106	Attendance of UTC-specific training courses for UTCs that have courses.	**Source:** MRA medical readiness training POCs. **Exception:** ANG units see para. 10.6.3.2.
Human Remains Preservation Training	Just-in-time, upon receipt of deployment tasking	N	AFI 41-106	Designed to provide an understanding of human remains preservation, including retrieval and processing, cultural implications, and medical planning, including technician safety.	**Source:** AFMAN 10-100 and presentation at: https://kx.afms.mil/kxweb/dotmil/file/web/ctb_077667.pdf

Table A3.3. CATEGORY III – UNIT TRAINING. Category III training is accomplished at the unit and is required for all assigned personnel.

Training Requirement	Minimum Frequency	Reportable	Reference	Definition	Remarks/Training Source
MCRP Team Training	Every 12 months	N	AFI 41-106 AFI 10-2501	Requirements determined by MCRP annexes, installation plans, and local requirements. Personnel who are not assigned to MCRP teams are not required to complete MCRP Team Training.	See para. 6.5.3. Source: A list of MCRP team training requirements is available on the AF Medical Readiness CoP.
Unit Mission Briefing	Initial upon unit assignment	N	DODI 1322.24 AFI 41-106	Detailed explanation of the unit's role during mobilization in support of expeditionary and installation response operations.	See para. 6.5.1. **Source**: MRDSS ULTRA can provide the MRL data for the unit. The Capability Overview screen in MRDSS ULTRA provides UTC personnel information, the unit's generation missions, and assigned WRM and installation response assets. A sample briefing is provided on the AF Medical Readiness CoP
AF Medical Service Mission Briefing	Every 12 months	N	DODI 1322.24 AFI 41-106	Basic tenets of the AFMS mission to include expeditionary, peacetime baseline and home station medical response.	See para. 6.5.2. **Source**: AF Medical Readiness CoP

Table A3.4. ANG CERFP/HRF Training. The following training is required for ANG personnel assigned to support CERFP and/or HRF missions.

Course Info	OPR	Source	Duration	Frequency	Required for the following Personnel
Air Force Emergency Response Operations (AERO) Command and Control Equivalent to ICS 100,200,700,775 and 800	AFEM-Air Force Emergency Management	Online ADLS Website, Available at Alpena Computer Lab	6 hours	One Time	All
HAZMAT Awareness	NFPA	Online ADLS Website, Available at Alpena Computer Lab	8 hours	One Time (with annual refresher)	All
HAZMAT Operations	NFPA	Local/State	24 hours	8 hour annual refresher required	All EMTs and PAs; optional for remaining team members
ANG CBRNE Medical Casualty Course (ANG CMCC)	ALPENA	Didactic and Field Training/MTT Available	120 hours	Required every 2 years alternate with EPRC	Providers, RNs, S&E 4N0X1, 4N0X1, and PH and BEE*
CBRNE Emergency Preparedness Response Course (EPRC) - short course	DMRTI	Online	8 hours	Required every 2 years alternate year with ANG CMCC	Providers, RNS, S&E 4N0X1, 4N0X1, and PH and BEE*
Search and Extraction Basic Course	RIG OK	Didactic and Field Training	60 Hours	One Time	S&E Medics
Advanced Cardiac Life Support	American Heart Association	Local	16 hours initial/8 hours recurring	Required every 2 years	Providers and RNs
Pediatric Advance Life Support	American Heart Association	Local	16 hours initial/8 hours recurring	Required every 4 years	Providers and RNs

Course Info	OPR	Source	Duration	Frequency	Required for the following Personnel
Advance Trauma Life Support	American College of Surgeons	Local	24 hours	Required every 4 years	Providers*
***Note:** For dual-tasked units, only FFEP3/FFEP4 UTC personnel are required to comply with these training requirements.					

Table A3.5. FIELD TRAINING. UTC-specific courses, expeditionary medical readiness training (EMRC), basic expeditionary medical Readiness Training (BEMRT), and commissioned officer training (COT) will ensure their curricula provide the field medical readiness training elements listed below. Deviations from these requirements must be approved by the RTOC.

Training Requirement	Definition
Shelter Assembly	This training provides a safe, ergonomic orientation to shelter assembly. Training will be consistent with those shelters appropriate to that unit's mission.
Field Sanitation and Hygiene, Disease Prevention.	This training will consist of personal hygiene, food and water handling, waste disposal (human and medical), and other medical responsibilities. Operational measures for countering endemic disease, prevention of non- battle injuries, mental health, countering disease vectors in field and urban environments, environmental health threats, and force health surveillance will be covered.
Low-Light and Black-Out Operations	Conduct medical operations during non- daylight hours with casualty reception and treatment at night as the primary focus.
Site Security	This training will include principles and techniques for deployed medical facility security. Include an overview of applicable LOAC policies (see Atch 7 for medical-specific guidance), force protection measures, and emergency communications procedures.
Fire Fighting	Review fire fighting techniques as applicable to deployed medical facilities and structures. Include a review of patient evacuation procedures in the event of a fire or explosion at a deployed medical facility.
Casualty Movement	Focus on techniques and procedures used to move casualties from one point to another, including basic litter carries, casualty loading, and casualty evacuation as appropriate to unit mission. During litter training, cover the basics of good body mechanics and proper commands, placing a patient onto the litter, using an overweight litter, proper strapping, 2-person and 4-person lifts/carries, 2 to 4/4 to 2 person switches, overhead lifts and use of vehicles of opportunity for litter loading/unloading. As part of casualty evacuation, include skills necessary for driving while wearing MOPP gear.
Operational Command, Control and Communications	This training will cover those activities that use information and business management systems to facilitate day-to-day operations in support of operational missions, including the use of radio communications, Information Management/Information Technology (IM/IT). Review AFTTP 3-42.1, *Health Service Support Command and Control in Deployed Operations*, and AFM 10-100, *The Airman's Manual.*
Wound & Casualty Management	This training will include clinical aspects of medical management of casualties and disease non- battle injuries, particularly triage and initial evaluation; use of auto injectors; gunshot wounds; vascular, neurological, orthopedic, maxillofacial, and hypo/hyper thermal stress injuries; burns, bandaging, and splinting; hypovolemic shock; eye injuries; and use of blood products.
Combat Stress Control (CSC)	This training will focus on familiarization with basic principles of CSC management, as well as leadership, communication with troops, unit morale and cohesion and individual psychosocial stressors, before, during and after deployment.

ATTACHMENT 4

MEDICAL READINESS COMMITTEE (MRC) MINUTES FORMAT

A4.1. General. The format below is prescribed for MRC minutes. Any modifications, to include agenda items omitted due to specific mission or facilities limitations, must be identified and approved in writing by the MRC chairman. File a copy of that approval with copies of historical minutes.

A4.2. Format. Prepare MRC minutes using standard AF letterhead, following the format below. All agenda items must be designated as Open, Closed or Info. Items not addressed during a specific meeting should be identified in the minutes as "No update provided." Use slides to provide statistics, status of open items, upcoming events and other informational requirements. Slides should be attached to minutes following the meeting. Examples of MRC briefing slides are available on the AF Medical Readiness CoP.

STANDARD LETTERHEAD

MEMORANDUM FOR *insert/identify Medical Group#* EXECUTIVE COMMITTEE

FROM: *Unit/MR Office Symbol*

SUBJECT: Minutes for the Medical Readiness Committee (or Executive Management Committee for ARC)

1. **PLACE:** *Identify Meeting Location*

2. **DATE AND TIME OF MEETING:** *Day, date, time*

3. **ATTENDANCE:** (*See list of required members in AFI 41-106 paragraph 4.3.1*):

   a. Members present: *Identify and list (begin with Chairman and list by rank with unit/office symbol, title and/or position).*

   b. Members absent: *List in same format as above.*

   c. Visitors: *List with same information/format as above and include who they're representing, if applicable.*

4. **REVIEW OF PREVIOUS MINUTES:** The minutes of the *insert date* meeting(s) were approved as written/with corrections.

5. **STANDARD AGENDA ITEMS:**

   a. Unit Plans Review: *Provide status of required plans reviews. See paragraph 4.3.2.1.*

   b. Medical Readiness Training Update: *Brief and discuss required MRT. See paragraph 4.3.2.2 and Attachment 3.*

   c. MCRP Team Chief Update: *Team chiefs should brief team staffing, status of assigned 886 AS, and training for their teams as listed in the Minimum MCRP Team Training matrix on the AF Medical Readiness CoP. See paragraph 4.3.2.3.*

   d.UTC Team Chief/Family Group Leader Update: *Brief team staffing and overall team status. See paragraph 4.3.2.5.*

e. Exercise Update: *Review the training and exercise schedule and make any necessary adjustments. Present and discuss PIES and exercise AARs. Identify any lessons learned which should be entered in JLLIS. See paragraph 4.3.2.6.*

f. UDM Update: *Address UTC personnel and deployment activities. See paragraph 4.3.2.7.*

g. Deployment AAR Update: *Present and discuss deployment AARs. Identify any lessons learned which should be entered in AF-JLLIS. See paragraph 4.3.2.8.*

h. Logistics Update: *Logistics personnel brief materiel status. See paragraph 4.3.2.9.*

i. Unit Reports Update: *Discuss SORTS, ART, and DRRS, being careful to treat classified material appropriately. See paragraph 4.3.2.10.*

j. Inspection Results Update: *Include open items from any inspection or SAV. See paragraph 4.3.2.11*.

k. MC-CBRN Program Update: *See paragraph 4.3.2.4.*

l. Other topics as directed by the Chairman: *Brief other items of interest to the committee. For examples see paragraph 4.3.2.13.*

6. **OLD BUSINESS:** *Office of Primary Responsibility (OPR) will identify item or issue (include dates) and provide brief status update with an Estimated Completion Date (ECD) if applicable. Label each OPEN, CLOSED or INFO.*

7. **NEW BUSINESS:** *Identify item or issue (include dates) and provide brief summary/description. Assign an OPR (Rank first/last name, office symbol) who will identify corrective action and provide an ECD at the next meeting. Label each item OPEN, CLOSED or INFO. Add new topics as necessary.*

   a. Medical Resource Letter Review: *Commander review is required to be documented annually or whenever a change occurs and documented in the next MRC minutes.*

   b. DOC Statement Review: *Commander review is required to be documented annually or whenever a change occurs.*

8. **OPEN ITEMS REFERRED TO OTHER COMMITTEES/INDIVIDUALS:** *Identify items which need to be addressed by other committees (Executive Committee or Education and Training Committee, as examples). Label each item OPEN, CLOSED or INFO.*

9. **DATE/TIME/PLACE OF NEXT MEETING:** *Identify day, date, time, and location of next meeting.*

FIRST M. LAST, 1Lt, USAF, MSC
Medical Readiness Officer

FIRST M. LAST, Colonel, USAF, MSC
Chairperson, Medical Readiness Committee

ATTACHMENTS: number and list each attachment in the order discussed. Examples follow.

1. Agenda
2. MCRP Review Status
3. RSVP Training Statistics
4. UTC Training Statistics
5. Deployment Training Statistics

6. Exercise Status
7. Red October After-Action Report
8. Field Medical Unit Readiness Training After-Action Report
9. Code Black After-Action Report
10. Dr. Savage After-Action Report
11. UTC Personnel Assignment fill rate
12. Upcoming Deployments
13. Team Chief Updates
14. 886 AS Status by MCRP Team
15. WRM Materiel Status
16. Unclassified Unit Reports Data
17. Inspection Schedule
18. Inspection Open Items
19. MC-CBRN Program Funding Status

DISTRIBUTION:
MAJCOM/SGX, MRC Members, MCRP Team Chiefs, UTC Leaders, AFSC Functional Training Managers, etc.

ATTACHMENT 5

MC-CBRN ALLOWANCE STANDARD REQUIREMENTS[1]

Allowance Standard	In-patient MTFs	Out-patient MTFs	LS and LSISS MTFs[2]	Air National Guard Non-Collocated Units[3, 4]	Air Force Reserve Non-Collocated Units
886 A	R	R	NR	R	NR
886 D	R	NR	NR	NR	NR
886 E	R	R	M	NR	NR
886 H	R	R	M	R	M
886 I	R	R[4]	M[4]	NR	NR
886 J	R	R	M	NR	NR
886 K	R	R	NR	R	NR
886 L	R	R	M	NR	NR
886 M	R	R	NR	NR	NR
886 P	R	R	M	NR	M

R= Required

NR=Not Required

M= Some level of capability is required. Units may modify assigned 886AS packages with MAJCOM approval in order to provide an appropriate level of capability.

[1] Reference the Medical Resource Letter (MRL) for MC-CBRN AS assignments.

[2] Unless agreements specify that capabilities are not required

[3] ANG packages differ slightly from active duty packages.

ATTACHMENT 6

EXERCISE REQUIREMENTS

Exercise	Reference	Frequency/Remarks
Medical Continuity of Operations (MCOOP)	AFI 41-106	MCOOP exercise required annually. May alternate actual relocation of the command and control function and tabletop exercise every other year. Not applicable to ARC. Also required for LS and LSISS MTFs.
Recall - MCRP Teams - UTCs - Deployment support teams - Unit-wide	AFI 41-106 Installation Deployment Plan (IDP)	Two unit-wide recalls per year. Must exercise each other category once per year, at a minimum. May be conducted simultaneously, but separate from the unit-wide recall. LS and LSISS MTFs must conduct two annually. One must be a full recall and the other may be telephonic. Deployed MTFs must conduct a unit-wide recall or personnel accountability exercise every three months.
National Disaster Medical System (NDMS)	DODD 6010.22	Any unit with a formal NDMS role must exercise its NDMS plan IAW DODD 6010.22; planned in Exercise Requirement Cycles. One Exercise Requirement Cycle is three calendar years. The requirement per cycle is one Field Training Exercise (FTX) and two Tabletop or Walkthrough Exercises (TTX). NDMS exercises may be conducted in conjunction with and/or incorporated into other exercises.
Disease Containment Plan Exercise	AFI 10-2603 AFI 10-2604	Can combine exercising the MTF's mass prophylaxis plan and disease containment strategy. Use realistic outbreak scenarios appropriate for the installation's mission and vulnerabilities. LS and LSISS MTFs that do not maintain the 886E and 886P AS may conduct this exercise in a tabletop format.
Major Accident	AFI 10-2501	IAW Base/wing exercise schedule and/or Commander's discretion. ARC response is based on the BSP/EMP as appropriate.
Natural Disasters	AFI 10-229 AFI 10- 2501	Scenario should be typical to unit's geographical area.
Terrorist Use of CBRNE	AFI 10-2501	Required twice annually. Scenarios should incorporate all local response elements and include improvised explosive devices as well as the other parts of CBRNE. Ensure all facets of MC-CBRN response, including patient decontamination, triage, manpower and security, etc. are exercised and trained. LS and LSISS MTFs required to maintain MC-CBRN AS must conduct this exercise.
Deployment Exercise	AFI 10-403	Frequency as determined by the IDP and will include exercising the entire range of deployment support activities.
Operational Readiness Exercise (ORE)	AFI 10-2501	Schedule established by the wing.

ATTACHMENT 7

APPLICATION OF THE LAW OF ARMED CONFLICT

A7.1. General. As a matter of Air Force policy, medical personnel may deploy as either noncombatants or combatants. The protections afforded under the Geneva Conventions are different for each category, and therefore, medical personnel should verify their status and the consequences of that status prior to deployment.

A7.2. Noncombatants. Medical personnel are considered noncombatants if they are *exclusively engaged* in performing medical duties. This includes supporting duties such as medical records, administration, disease prevention, and the variety of missions performed by Bioenvironmental Engineering personnel for the purposes of prevention of disease/sickness through health risk assessment and control. Noncombatants may carry weapons for self-defense, defense of patients, or defense of other noncombatants such as their co-workers. However, medical personnel may not engage in actions that are harmful to lawful enemy combatants, such as offensive military operations, convoy operations, or laying minefields, without losing their noncombatant status for the duration of their deployment and subjecting themselves to being targeted by the enemy. If captured, true non-combatants are considered *retained personnel* and not *prisoners of war*.

A7.3. Combatants. Medical personnel may deploy as combatants and as such are prohibited from appearing as noncombatants while deployed in a combatant capacity. This means that while serving in a combatant role:

A7.3.1. Medical personnel may not wear the large red cross armband.

A7.3.2. Medical personnel may not carry the DD Form 1934, *Geneva Conventions Identification Card.*

A7.3.3. Medical personnel are not entitled to special protection against enemy attacks. (In this scenario, medical personnel are lawful targets.)

A7.3.4. Upon capture, medical personnel in combatant roles are considered *prisoners of war* rather than *retained personnel*. However, the capturing force may elect to use the captured medical personnel in their medical capacity instead. In that event, the medical personnel would be entitled to the same treatment as retained personnel.

A7.4. Disclaimer. This section is not intended to answer all of the possible scenarios for medical-legal issues relating to combatants and noncombatants. The Air Force Judge Advocate General should be consulted for answers to specific questions. Also, AF/JAO has published specific legal reviews for medical personnel and those documents should be reviewed (see AF/JAO Memorandums dated 08 Sep 08 at on the AF Medical Readiness CoP assessable through the AF Portal.

ATTACHMENT 8

NATIONAL RESPONSE PLANNING SUMMARY

A8.1. General. This attachment provides additional information on the plans and documents associated with the National Response Framework (NRF) and references support in deployed locations. Refer to the documents cited for full explanations. The national plans are as follows:

A8.1.1. **Defense Support to Civil Authority (DSCA).** Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the President may direct any federal agency to provide support to State and local agencies. AFI 10-802, *Military Support to Civil Authorities,* outlines how the Air Force will provide support under four situations: immediate response, Memorandum of Understanding/Memorandum of Agreement, Presidential Declaration, or 10-Day Rule.

A8.1.1.1. For emergency management operations requiring medical assets to be deployed, installation assets may be tasked under the Immediate Response Authority outlined in DODD 3025.1 or through formal tasking procedures outlined in DOD or Joint Staff guidance.

A8.1.1.2. Local emergency management operations occurring at or near an AF installation will be directed by the installation commander following guidance maintained in the NRF and the installation CEMP 10-2.

A8.1.2. **The National Response Framework (NRF) (N/A for AFRC).** The NRF provides the structure and mechanisms for coordinating federal support to state and local governments. The NRF distinguishes between incidents that require Department of Homeland Security (DHS) coordination, and the majority of incidents occurring each year that are handled by responsible jurisdictions or agencies through other established authorities and existing plans. The NRF outlines a standardized organizational structure for command, control and coordination through the Incident Command System (ICS). In addition, the organization of response capabilities is grouped into Emergency Support Functions (ESFs), which outline the responsibilities of different agencies in providing support during an emergency.

A8.1.2.1. The MR office should be thoroughly familiar with ESF 8 in the NRF, particularly the functions listed for DOD. Medical units should establish mutual aid agreements (MAAs) with area medical facilities, ambulance services, etc., to ensure medical capabilities not organic to the MTF are available outside the installation during duty and non-duty hours. See AFM 10-2502, *USAF Weapons of Mass Destruction (WMD) Threat Planning and Response Handbook,* for additional considerations in developing MAAs.

A8.1.2.2. For ESF 11, the primary agencies are the Departments of Agriculture and the Interior. Under these agencies, the AFMS may be tasked to provide laboratory and diagnostic support.

A8.1.3. **National Incident Management System (NIMS) (N/A for AFRC).** The Department of Homeland Security provides oversight to emergency management through the NIMS. The NIMS provides a consistent nationwide approach to enable Federal, State, Local, and Tribal governments and private- sector and nongovernmental organizations to work

together effectively and efficiently to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity, including acts of catastrophic terrorism. The NIMS directs the use of a common ICS, common terminology for ordering and tracking resources, and effective communications among responders, EOCs and with the public. The ICS is a standardized organizational structure used to command, control, and coordinate the use of resources and personnel that have responded to the scene of an emergency.

A8.1.4. **Air Force Incident Management System (AFIMS).** The AF has tailored the NIMS to fit within the AF structure and meet unique AF requirements with the AFIMS. The AFIMS provides the Air Force with the coordinating structures, processes, and protocols required to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents. In accordance with the AFIMS structure, the incident commander has tactical control of medical personnel at the incident site. MCRP teams that operate at the MTF report to the EOC through the MCC. AF Instruction 10- 2501, *AF Emergency Management Program, Planning and Operations*, implements the AFIMS and aligns AF Emergency Management (EM) planning and response with the National Response Framework (NRF).

A8.1.4.1. The Incident Commander (IC) is a trained and experienced responder who provides on-scene tactical control of an incident using subject matter experts (SMEs) and support from other functionals. Normally ICs are senior fire or police personnel who've completed IC training. Incident management personnel who represent the major functional elements of the ICS comprise the ICS General Staff. These include section chiefs for: Operations, Planning, Logistics, and Finance/Administration.

A8.1.4.2. The AFIMS IC, normally the fire chief, will use the AFIMS to conduct emergency management operations. Depending upon the situation, other personnel may function as ICs if they have completed ICS training and meet DOD and Federal certification standards for the specific type of incident. A senior medical person (either the MTF commander or the Public Health Emergency Officer) could be designated the IC for biological disease outbreaks, such as Severe Acute Respiratory Syndrome or pandemic flu, that occur on the installation. Attachment 2 in AFI 10-2501 shows the installation OPR for each ESF, identified on the basis of authorities, resources and capabilities.

A8.1.4.3. The Installation Control Center (ICC) directs strategic actions supporting the installation's mission. The command post is part of the ICC, which functions as the essential C2 node. The ICC provides a communication link with higher headquarters and with civilian agencies. As the focal point for installation-wide warning, notification and operations, the ICC communicates directions and information, and also recommends courses of action concerning the incident. The ICC advises the Commanders Senior Staff and directs the EOC and UCCs. The Installation Commander serves as the senior leader of the ICC.

A8.1.4.4. Within the AFIMS construct, the Medical Team, which supports the ICC, includes the full spectrum of health services support provided by the base MTF, whether in an expeditionary or home station setting. MCRPs address specific roles, responsibilities, processes and procedures associated with medical response to emergencies and disasters, whether natural or manmade, including conventional attacks and acts of terror. Format, content, development and maintenance of the MCRP are addressed in Attachment 2 of this Instruction.

ATTACHMENT 9

DEPLOYED MTF ASSESSMENT TOOL

POC	Activity	Applicability
	COMMANDERS/SUPERINTENDENT/FIRST SERGEANT:	
	Walk-through conducted with review of mission, manning, facilities, logistics processes and resultant capabilities/challenges	All Deployed MTFs
	Maintain awareness of relevant theater, task force, Wing, MTF policy guidance	All Deployed MTFs
	Maintain awareness of current theater medical intelligence	All Deployed MTFs
	Establish/Sign G-series orders and appointment letters, as appropriate	All Deployed MTFs
	Appoint infection control and patient safety officers	Sustainment MTFs
	Establish and maintain contacts with MTF chain of command, key joint/coalition installation organizations, and as required, host nation/interagency/NGO partners to ascertain mission objectives and expectations	All Deployed MTFs
	Upon arrival, read after-action reports/lessons learned/exit interviews and OPEN issues from previous leadership team	All Deployed MTFs
	Establish leadership team battle rhythm to cover key meetings and address operational mission requirements	All Deployed MTFs
	Establish schedule of routine reports to ensure timely completion/distribution to required recipients	All Deployed MTFs
	Ensure LOEs/decorations are submitted IAW unit policies	All Deployed MTFs
	Establish/confirm procedures for intra-theater/intertheater patient movement	All Deployed MTFs
	Establish/Confirm operable Communications systems: TMIP (all applications), TC2, TBMCS, SIPR, NIPR, STE/STU, etc.	All Deployed MTFs
	Establish a List of Critical Equipment/Supplies with minimum thresholds and a process to periodically monitor the status	All Deployed MTFs
	Ensure personnel field living conditions are monitored and addressed: messing, quarters, sanitation/hygiene	All Deployed MTFs
	Maintain protocols for special situations: GO1B, Detainee ops, support of Controlled Access programs, etc.	All Deployed MTFs
	Maintain emergency contact information for all assigned personnel	All Deployed MTFs
	Ensure all personnel are met upon arrival, in-processed, and assigned quarters	All Deployed MTFs
	Ensure all personnel attend mandatory base in-processing and out-processing	All Deployed MTFs
	Ensure required personnel complete on/off base driver courses to include flightline orientation, as appropriate	All Deployed MTFs
	Ensure Team Chiefs conduct routine meetings to review assembly locations and EMDG/WG emergency management plans	All Deployed MTFs
	In coordination with deployed PERSCO, review/validate the Deployment Requirement Manning Document against TPFDD RDDs/RLDs monthly to manage risks associated with AEF Force Pivot gaps and overlaps. Work issues with AFFOR/SG	All Deployed MTFs
	Ensure operating instructions, MOU/MOA/MAA, policy letters and plans are current and reviewed within the last 12 months	All Deployed MTFs
	Establish a facility access control procedures to clearly identify volunteers or other personnel separately from medical personnel, given the facility size, security risk, and access requirements	All Deployed MTFs

POC	Activity	Applicability
	SGH/SGN/SGP/SGZ/SGB/SGA:	
All	Establish 24/7 on-call in-house duty schedules for critical care, surgical, and other key functions. Ensure procedures are in place to contact/recall these key personnel when necessary	All Deployed MTFs
SGH	Establish a schedule for regular prostaff meetings and interdisciplinary patient rounds	All Deployed MTFs
SGH	Maintain awareness of provider ITBs	All Deployed MTFs
All	Ensure staff competence to perform duties is documented in Training Folders, RSVP Competency Assessment Folders, and/or provider interfacility credential transfer briefs from home station medical facilities, as appropriate	All Deployed MTFs
All	Provide initial provider staff orientation within 1 week of arrival, to include at a minimum: equipment operation (i.e. vents, PCAs, pumps, etc.), operating instructions, policies, patient safety, infection control, and CPGs	All Deployed MTFs
All	Establish ongoing education programs, including in-service training and other activities to maintain and improve staff competence	All Deployed MTFs
All	Establish and ensure staff is trained on admission/care procedures for detainees, local nationals, non-coalition civilians, and security personnel safeguards	All Deployed MTFs
SGH	Maintain awareness of established theater CPGs and ensure provider compliance	All Deployed MTFs
All	Maintain awareness of established transfer policies and procedures, available host nation medical facilities, and other available resources for patient disposition	All Deployed MTFs
All	Maintain bed capacity and inpatient staffing plans, to include staff recall procedures, for surge operations	All Deployed MTFs
SGP	Maintain contact with OG and flying squadron CC's to identify mission objectives and aeromedical support requirements	All Deployed MTFs
SGP	Ascertain FS flying opportunities in terms of aircraft type and/or mission restrictions; flying squadron expectations regarding FS mission preps	All Deployed MTFs
SGP	Maintain awareness of fatigue issues and counter fatigue management program to include Go/No Go policy, processes and inventories	All Deployed MTFs
SGP	Establish DNIF procedures, 1041 log, and review requirements	All Deployed MTFs
All	Establish patient movement processes (RW+FW) with PAD/patient element team and FS aeromedical clearance duties	All Deployed MTFs
All	Ensure staff is trained on patient preparation for aerovac/medevac movements in coordination with the other U.S. service components and coalition forces as necessary	All Deployed MTFs
SGP	Coordinate an equitable duty schedule for all FSs (including SME docs) and IDMTs (clinic, CASF, AE support, flying, etc)	All Deployed MTFs
SGP	Maintain awareness of key ground and aviation Wing Safety program elements/concerns to include aircraft mishap response	All Deployed MTFs
	READINESS (ref. AFI 41-106)	
	Establish recall procedures to achieve rapid accountability of all MTF personnel following attack/disaster (FMC/PMC/NMC); exercise procedures every three months	All Deployed MTFs
	Ensure contingency response capabilities are included as part of installation's CEMP and that applicable medical procedures and associated checklists are reviewed annually	Sustainment MTFs
	Assign personnel to CEMP Disaster Team and Team Chief positions	All Deployed MTFs

POC	Activity	Applicability
	Maintain awareness of relevant OPLANS, intelligence, threat and vulnerability assessments	All Deployed MTFs
	Ensure MCC or C2 element has been trained on, has access to, and monitors necessary communications such as TBMCS and relevant MIRC chats (TFMED, Battlespace Owner, etc.)	All Deployed MTFs
	Review base emergency management plans to include CEMP, aircraft mishap response, and DCP at least quarterly; ensure associated medical procedures are current	All Deployed MTFs
	PATIENT SAFETY	
	Establish a standardized process to maintain and/or improve effectiveness of communication and seamless patient hand-off between caregivers throughout the medical facility and patient movement systems. Ensure patient's name and age, vital signs, relevant medical history, symptoms/diagnosis, critical lab values, current medications (incl. PCA and infusion pump settings), actions already taken, level of urgency, and anticipated changes are accurately relayed	All Deployed MTFs
	Establish a mechanism to monitor and/or improve the timeliness of reporting and receipt of critical tests, results, and values by responsible licensed caregiver	All Deployed MTFs
	Establish a mechanism to report, investigate, and track trend analyses of patient safety incidents (to include Sentinel Events and Near Misses) to identify root causes for ultimate resolution and prevention of future occurrences	All Deployed MTFs
	Establish a process for all clinical staff to confirm patient identification using patient identifiers, (preferably two)	All Deployed MTFs
	Maintain contact numbers of receiving and sending medical facilities to facilitate time/content critical patient transfer reports in addition to written documentation methods	All Deployed MTFs
	Ensure inpatient and outpatient care is appropriately documented and made available to other treating providers in the healthcare system. Electronic health records should be used to the greatest extent possible to facilitate inter-facility data transfer and long-term capture in the patient's medical record	All Deployed MTFs
	Establish and track a fall prevention program	Sustainment MTFs
	Ensure appropriate litters (OSL or NATO) and pads and spinal precautions are utilized for patient transport	All Deployed MTFs
	Ensure all medication and medication containers (e.g. syringes, medicine cups, basins) are labeled	All Deployed MTFs
	Ensure separate refrigerators are used for medications, food and specimens and appropriate temperatures are maintained and monitored; biological refrigerators have a biohazard label	All Deployed MTFs
	Ensure multi-dose vials are dated and initialed when opened and discarded after 28 days, or sooner per manufacturer's instruction.	All Deployed MTFs
	Ensure expired medications are disposed of properly	All Deployed MTFs
	Ensure stock drugs, including crash cart meds, are checked monthly for expiration dates	All Deployed MTFs
	Ensure external and internal medications are stored on different shelves or maintained separately	All Deployed MTFs
	Ensure discharged patient medications are returned to pharmacy	All Deployed MTFs
	Ensure an appropriate supply of properly labeled prescription medications, narcotics, intravenous fluids, antibiotics, and feedings are provided for AE patients, IAW TRANSCOM guidance	All Deployed MTFs

POC	Activity	Applicability
	Ensure a periodic review of similarly named drugs is conducted and action is taken to prevent incorrect exchange of drugs; list is communicated to all medical staff.	All Deployed MTFs
	Ensure controlled medications are accurately reconciled and account for medical supply items such as needles and syringes, across the continuum of care, including AE system	All Deployed MTFs
	Ensure access to medications is appropriately controlled based on drug schedule, and inventories are appropriately conducted	All Deployed MTFs
	Ensure destruction of drugs is appropriately documented and maintained for future validation	All Deployed MTFs
	Ensure an approving official is appointed for procurement and receipt of Schedule II controlled substances	All Deployed MTFs
	Ensure duties for ordering, receiving, recording, and dispensing of controlled drugs are separated.	All Deployed MTFs
	Ensure an approved IV medication nursing administration list is published	All Deployed MTFs
	Establish an in-house Trauma registry	Sustainment MTFs
	Ensure audits of all deaths are conducted	All Deployed MTFs
	Participate in JTTR and JTTS weekly Trauma conference/VTC or theater equivalent	Sustainment MTFs
	Participate in weekly Patient Movement conference/VTC or theater equivalent	Sustainment MTFs
	Conduct reviews of pre-hospital trauma care, as appropriate	All Deployed MTFs
	Conduct reviews of times and reasons for trauma related bypass	Sustainment MTFs
	Conduct reviews of times and reasons for transfer of injured patients	Sustainment MTFs
	Conduct regular M&M conferences using theater-specified format; forward minutes to JTTS with action plan	Sustainment MTFs
	Ensure MTF and CASF personnel provide conscious patients an anti-hijacking briefing, that Anti-Hijacking Statements are completed, all patient baggage is tagged and place the tag number is annotated on Anti-Hijacking Verification for the Medical Crew Director; procedures are accomplished prior to patients entering aircraft and are signed by an MTF/CASF representative	All Deployed MTFs
	INFECTION CONTROL	
	Ensure representatives from relevant components/functions within the MTF collaborate to implement an infection control program based on a mission-oriented IC Risk Assessment, level of care (AE, Aid Station, MTF, clinic, etc), resources, patient population, epidemiologically significant microorganisms, procedures performed in the healthcare facility, and environmental factors	All Deployed MTFs
	Develop a unit specific IC orientation for all HCWS and volunteers, to include discussion of: CDC guidelines, unit OIs, BBP program and exposure reporting procedures, PPE, and epidemiologically significant microorganisms , (i.e., Acinetobacter, MRSA, etc.) before providing patient care	All Deployed MTFs
	Establish procedures to diagnose, treat, and prevent infectious diseases in healthcare workers and transmission of communicable diseases between staff and patients	All Deployed MTFs
	Ensure all HCWs and volunteers routinely perform hand hygiene between patient contacts and soap/sanitizer dispensers and towels are conveniently located to promote regular use	All Deployed MTFs
	Ensure a bloodborne pathogen program is in place	Sustainment MTFs

POC	Activity	Applicability
	Ensure alternative hand cleansers (i.e., Alcare, Purell Hand Sanitizer) are readily available in "no sink" areas or for use during water outages	All Deployed MTFs
	Implement HICPAC 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings to include standard precautions, transmission-based precautions, proper use/availability of PPE, respiratory hygiene/cough etiquette	Sustainment MTFs
	Ensure required PPE (i.e. gloves, gowns, face shields, masks, and goggles as indicated by task) is readily available	All Deployed MTFs
	Develop a strategy to prevent catheter-related blood stream infections	All Deployed MTFs
	Ensure environmental cleaning and storage of clean and sterile supplies is conducted in a clean, organized, environmentally controlled location, when possible	All Deployed MTFs
	Ensure all horizontal surfaces such as utility room counters, medication room counter tops and exam tables are cleaned daily and when soiled; office areas are cleaned weekly	All Deployed MTFs
	Ensure patient care equipment surfaces such as IV stands, suction machines, wheel chairs and bedside commodes are cleaned after each patient use and PRN	All Deployed MTFs
	Ensure crash cart exteriors are wiped down weekly	All Deployed MTFs
	Ensure approved antiseptic/disinfectant agents are properly diluted and labeled with the name, dilution strength, and date mixed	All Deployed MTFs
	Ensure mattress covers on beds/gurneys are in good repair and removed from use and replaced when necessary	All Deployed MTFs
	Ensure patient care items are not stored on the floor	All Deployed MTFs
	Maintain the facility in good repair (i.e. tentage, walls, windows, countertops, cabinets/drawers, storage)	All Deployed MTFs
	Ensure sterile water and sodium chloride are appropriately dated and discarded after 24 hours	All Deployed MTFs
	Ensure patient nutrition, medication, biohazard, and specimen refrigerator is maintained a the proper temperature and the temperature is checked and recorded daily	All Deployed MTFs
	Ensure that sterile items are maintained above non-sterile items and liquids are below paper items when stored together	All Deployed MTFs
	Ensure items are resupplied from right to left and back to front, checked weekly for package integrity, and inspection is documented; expired items are disposed of properly	All Deployed MTFs
	Ensure no items that can be damaged by water are stored under sinks	All Deployed MTFs
	Ensure warehouse boxes are not used for supply storage in main sterile storage room in OR; boxes emptied outside of clean supply room are not brought into the clean area	All Deployed MTFs
	Ensure respiratory equipment is stored with empty water reservoirs and covered to prevent dust accumulation	All Deployed MTFs
	Ensure single-use items such as water pitchers and urinals are labeled with the patient's name and room/bed number	All Deployed MTFs
	Ensure individual measuring containers used for patients with indwelling catheters/drainage tubes are labeled with the patient name and room/bed number	All Deployed MTFs
	Ensure medical waste is disposed of IAW Overseas Environmental Baseline Governing Document (OEBGD) or country-specific standards, if one exists	All Deployed MTFs

POC	Activity	Applicability
	Ensure sharp containers are conveniently located, stable and secured, and replaced when 3/4 full	All Deployed MTFs
	Ensure cleaning, disinfection and sterilization of reusable equipment and instruments is accomplished IAW AAMI guidelines and Spaulding's classification (critical, semi-critical, and non-critical items)	All Deployed MTFs
	Verify proper soaking/cleaning of instruments in central sterile supply	All Deployed MTFs
	Ensure autoclave-internal/external indicators are used in central sterile supply	All Deployed MTFs
	Ensure cleaning/sterilization of non-disposable supplies is done in non-patient care areas and in well-ventilated areas	All Deployed MTFs
	Ensure items are wiped clean with gauze then promptly submerged in enzymatic cleaner and/or returned to CSS; items are not left in treatment or utility rooms	All Deployed MTFs
	Ensure chemical sterilization processes are monitored for length of soaking, effective concentration of solution and temperature	All Deployed MTFs
	Ensure personnel use appropriate PPE when cleaning, soaking, manually cleaning and processing items	All Deployed MTFs
	Ensure pillows have plastic protective covers, constructed of an impermeable material or are disposable	All Deployed MTFs
	Ensure dirty and clean linen are stored separately	All Deployed MTFs
	LOGISTICS (ref. AFI 41-209)	
	Establish remote server logins and passwords for all newcomers NLT 48 hours after arrival; provide SIPRNET, TRACE2S, TMIP, TMDS, AHLTA-T, TC2, and PIMR access as required	All Deployed MTFs
	For logistics personnel establish access to: DMLSS, AFML webpage profile/list server updates, Shelf Life Extension Program (SLEP), Reachback website, and MED PDB	All Deployed MTFs
	Upon arrival, review QA, forward logistics plan, backorder reports, and outstanding Form 9 program	All Deployed MTFs
	Review service contracts and establish new support contracts with deployed contracting officer, as required	All Deployed MTFs
	Conduct the following initial/closeout inventories: PMI, vault, PI equipment, BW/CW, WRM, Equipment, Operating Inventory (accomplish certificates of completion for Equipment and Operating Inventory)	All Deployed MTFs
	Appoint a controlled item inventory manager, section property/supply custodians, PMEL manager, and accomplish a certificate of transfer to an accountable MSC	All Deployed MTFs
	Accomplish the following reports: 1. Weekly: CT Scanner status (as applicable) 2. Monthly: Form 9, vaccine, BW/CW, maintenance management, TLAMM backorder recon 3. Each AEF cycle: BW/CW, equipment and operating inventory 4. As needed: Reports of Survey	All Deployed MTFs
	Establish POCs and working relationships with supporting theater logistic resources, such as MEDLOG/TLAMM and PMI Cell Liaison	All Deployed MTFs
	Establish POCs and working relationships with supporting BOS resources, such as local inbound/outbound TMO, Vehicle Fleet Manager, base contracting officer, and CE	All Deployed MTFs
	Establish a system to ensure cold chain integrity throughout the delivery, receipt and storage phases, to include alerting mechanisms or back-up power for refrigerated medications	All Deployed MTFs

POC	Activity	Applicability
	Ensure all medical equipment (EKG, microscope, treadmill, etc) is stored properly and inspected regularly for functionality and accountability	All Deployed MTFs
NOTE: Sustainment MTFs are defined as those involved in enduring operations for more than two years with permanent (365 days) MDG/CCs, IAW para. 2.1.11.3.1.		